

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01725

01722

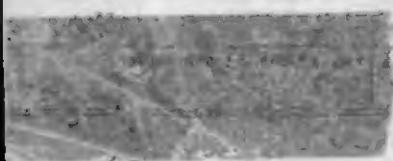
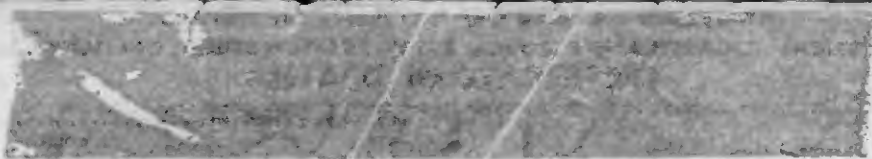
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1025 FLAGTREE LANE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>1025 FLAGTREE LANE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>ROBERT ERWIN ABRAMSON</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>8</u> Year <u>1967</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 21, 1911</u>		9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUYER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FURNITURE</u>				11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>HARRY ABRAMSON</u>						14. MOTHER'S MAIDEN NAME <u>ANNA</u>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-05-4278</u>				17. INFORMANT <u>FRANCES ABRAMSON - SAME</u>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> (b) <u>Arteriosclerotic Heart Disease</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }												INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 years</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>														19. WAS AUTOPERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 3, 1964</u> to <u>Feb 8, 1967</u> that (I) (was) last saw the deceased alive on <u>Feb 8, 1967</u> and that death occurred at <u>2A</u> M. from the causes and on the date stated above.																					
22a. SIGNATURE <u>Manuel Levin</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/8/67</u>		22c. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN</u>											
22d. ADDRESS <u>4818 REISTERSTOWN RD BALTO MD</u>						23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>								23b. DATE THEREOF <u>Feb 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u> </u>		23d. LOCATION (City, town or county) <u>BALTO MD</u>		(State)	
24 FUNERAL DIRECTOR'S SIGNATURE <u>SYLVAN S. LEVIN</u>						ADDRESS <u> </u>		25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01726

CERTIFICATE OF DEATH

01723

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 100 Westminster Road		d. STREET ADDRESS 100 Westminster Road	
3. NAME OF DECEASED (Type or print) First Carrie Middle H. Last Albright		4. DATE OF DEATH Month February Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1893
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months 03 Days 13 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Hoover		14. MOTHER'S MAIDEN NAME Anna Ragsadle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss. T. May Albright		Address Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Insufficiency - DUE TO Chronic Hypertension (c) Chronic Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2 days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-1- , 19 60 , to 2-13- , 19 67 , that (I) (we) last saw the deceased alive on 2-13- , 19 67 , and that death occurred at 10 P.M. from causes and on the date stated above.			
22a. SIGNATURE James G. Saffell		22b. DATE SIGNED 2-14-67	
22c. PHYSICIAN'S NAME (Type) James G. Saffell M.D.		22d. ADDRESS Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/67	
23c. NAME OF CEMETERY OR CREMATORY Black Rock		23d. LOCATION (City or Town) (County) (State) Butler Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE J. F. Eline & Sons		DATE FEB 16 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01727

CERTIFICATE OF DEATH

01724

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY in 1b 59 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1011 West Lanvale Street			
3. NAME OF DECEASED (Type or print) First Middle Last THEODORE - - - - ALEXANDER				4. DATE OF DEATH Month Day Year FEBRUARY 22 19 67			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 23, 1900	
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) CHARLOTTE, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS ALEXANDER				14. MOTHER'S MAIDEN NAME LENA MN: UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII				16. SOCIAL SECURITY NO. 212 16 94 26		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BROCHOGENIC CARCINOMA DUE TO (c)				INTERVAL BETWEEN ONSET OF DEATH DAYS MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (if this hospital) attended the deceased from DEC. 26 , 19 66 , to FEB. 22 , 19 67 that (I) (we) lost the deceased alive on FEB. 22 , 19 67 , and that death occurred at 11:45 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Sheldon E. Kalmutz</i>				22b. DATE SIGNED 2/23/67			
22c. PHYSICIAN'S NAME (Type) SHELDON E. KALMUTZ, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/27/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR <i>Charles A. Rice</i> 661				25a. REC'D BY REGISTRAR FEB 24 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
01728 Item 9 Film G506 3/1/67						01725					
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN Id 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ridge Way Manor Nursing Home						d. STREET ADDRESS 1245 E. Belvedere Ave. 21212				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERTRUDE			First			Middle			Last		
4. DATE OF DEATH February 20 19 67			5. SEX Female			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
8. DATE OF BIRTH June 13, 1891			9. AGE (In years last birthday) 76 75 yrs.			10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____			11. IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary						10b. KIND OF BUSINESS OR INDUSTRY Hospital			11. BIRTHPLACE (County & State, or foreign country) Baltimore City		
12. CITIZEN OF WHAT COUNTRY? U.S.A.						13. FATHER'S NAME Daniel Thomas					
14. MOTHER'S MAIDEN NAME Sauter						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					
16. SOCIAL SECURITY NO. 214-14-3545						17. INFORMANT James F. Allen					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 332X OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 hrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1960 to 20 20 , 19 67 , that (I) (we) last saw the deceased alive on 19 Feb 19 67 , and that death occurred at 4:45 M, from the causes and on the date stated above.											
22a. SIGNATURE William Goodman, MD						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Dr. William Goodman						22d. ADDRESS 1334 Sulphur Spring Road 21227					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-23-67			23c. NAME OF CEMETERY OR CREMATORY St. Johns Church Cemetery			23d. LOCATION (City, town or county) (State) Long Green Baltimore Co.		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.						25a. REC'D BY REGISTRAR 1217 St. Paul Street					
25b. REGISTRAR'S SIGNATURE Charles Judo						DATE FEB 27 1967					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01726

01729

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EastPoint		c. LENGTH OF STAY IN 1b Baltimore, # 21224, 304	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7917 E. Baltimore St., # 21224		d. STREET ADDRESS 2608 Foster Ave.	
3. NAME OF DECEASED (Type or print) THOMAS FRANCIS ALLEN, Jr.		4. DATE OF DEATH Month February Day 3 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1922
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY Bermuda Shipp. Co. New York, N.Y.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas F. Allen, Sr.		14. MOTHER'S MAIDEN NAME Rose Garrity	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.11 720-16-7279	
17. INFORMANT Ann Henriel		Address 90 Arcadia Rd. Allendale, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic alcoholism INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theodore C. Patterson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Theodore C. Patterson		DATE SIGNED 2/3/67	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-7-67	22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery, Long Island, N.Y.	22d. LOCATION (City, town, or county) (State) Long Island, N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeiler		24a. REC'D BY REGISTRAR ADDRESS 6224 Eastern Ave. Balto., 21224, Md.	24b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1995 10/10/95

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01730

01727

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
56 <u>Greater Baltimore Medical Center</u>		<u>2515 Hillford Drive</u>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last <u>Dorothy Alberta Allmond</u>		Month Day Year <u>2 - 12 19 67</u>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>10 - 15 '49</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)
<u>Housewife</u>			<u>Baltimore, Maryland</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Wm. J. Ritter</u>		<u>Bart J. Wilhelmina</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
<u>No</u>		<u>212055205 D</u>	<u>Mr. Floyd M. Allmond - 4322 Ridge Rd. #36</u>
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> <u>1750</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Carcinoma of ovary</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 23, 19 67</u> to <u>Feb. 12, 19 67</u> that (I) (we) last saw the deceased alive on <u>Feb. 12, 19 67</u> , and that death occurred at <u>9:05 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Robert W. Smith</u> M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>2-12-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Smith</u>		22d. ADDRESS <u>Greater Balto. Med Cen.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co., Maryland</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. 5305 Harford Rd. #14</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal; and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

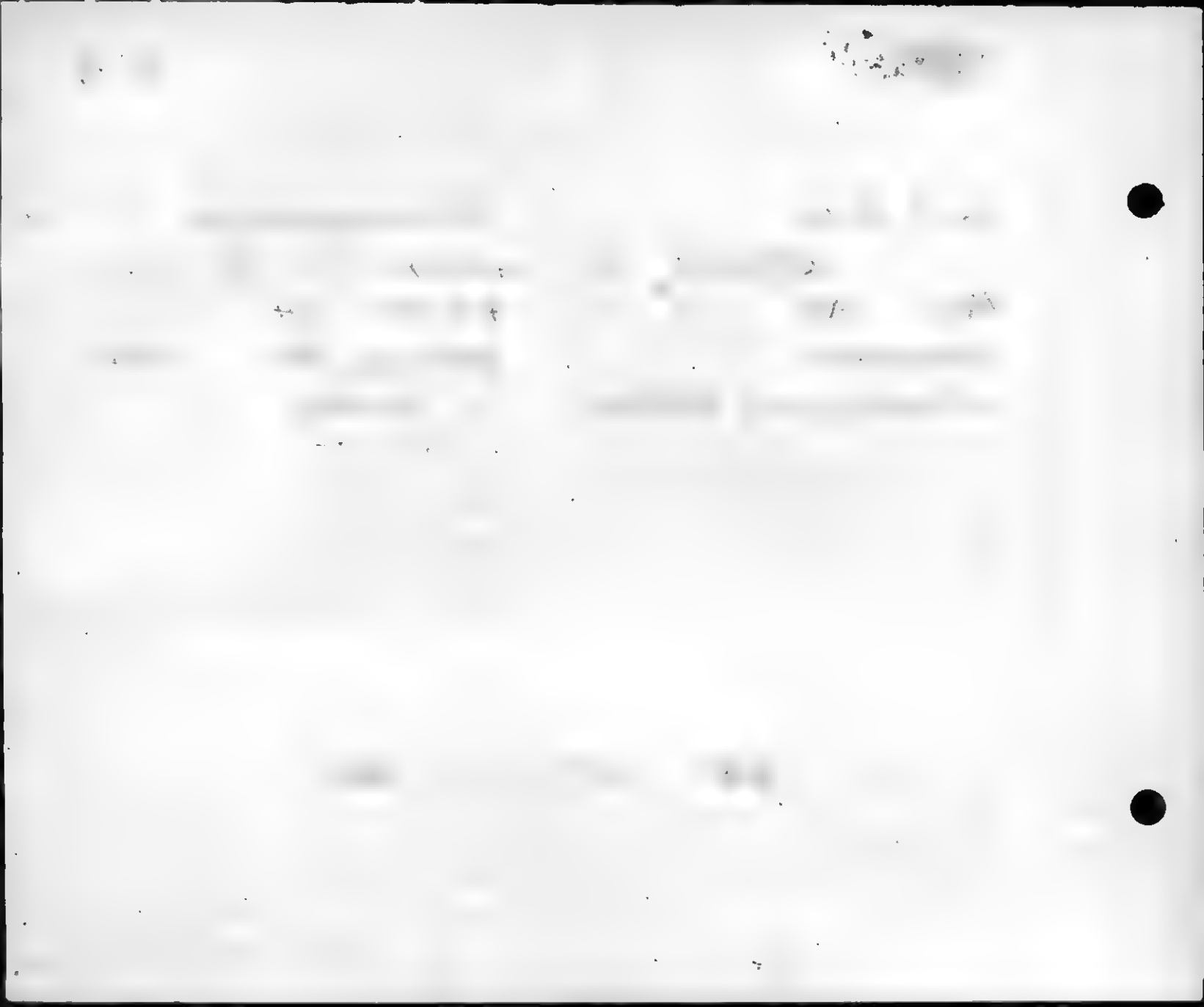
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01731

01728

1. PLACE OF DEATH a. COUNTY BALTIMORE				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) G. B. M. C.				d. STREET ADDRESS 5002 BELAIR ROAD			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES B Apple				4. DATE OF DEATH Month Day Year 2 5 19 67			
5. SEX MALE		6. COLOR OR RACE CAU.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-1-1902	
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LITHOGRAPHER		10b. KIND OF BUSINESS OR INDUSTRY Art-Litho Co.		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME CHARLES Lee Apple			
14. MOTHER'S MAIDEN NAME Catherin Kirby				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. 212-01-2524				17. INFORMANT Gloria E. Apple Address -5002 Belair Road-21206			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Cancer of Lung Rt DUE TO (c) metastatic							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1st, 1967 to Feb 5, 1967 , that (I) (we) last saw the deceased alive on 2-5 1967, and that death occurred at 2:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Edmundo Kapanaga				22b. DATE SIGNED 2-5-67			
22c. PHYSICIAN'S NAME (Type) EDMUNDO KAPANAGA				22d. ADDRESS G. B. M. C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-8-67		23c. NAME OF CEMETERY OR CREMATORY Foreland Memorial Park		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John C. Miller Jr. ADDRESS 6415 Belair Rd.				25a. REC'D BY REGISTRAR FEB 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01732

CERTIFICATE OF DEATH

01722

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN it <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Bhanche Winifred Arnold</u>		4 DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>19 67</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/10/03</u>
9 AGE (In years last birthday) <u>63</u> yrs		10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Saleslady</u>		11 BIRTHPLACE (County & State, or foreign country) <u>MARION, S. D</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Paul Wendelin</u>	
14 MOTHER'S MAIDEN NAME <u>Myer</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <u>No</u>	
16 SOCIAL SECURITY NO <u>526-05-6853</u>		17 -INFORMANT <u>Patient's Chart</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>gastrointestinal hemorrhage</u> DUE TO (b) <u>hemorrhagic cecitis with infarction</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 'o m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/3</u> , 19 <u>67</u> , to <u>2/9</u> , 19 <u>67</u> , that <u>we</u> last saw the deceased alive on <u>2/9</u> 19 <u>67</u> , and that death occurred at <u>7.30AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Juan L. Roque</u>		22b DATE SIGNED <u>2/9/67</u>	
22c PHYSICIAN'S NAME (Type) <u>JUAN L. ROQUE</u>		22d ADDRESS <u>68M.C. Balto 21204</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>2-11-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Co. Md.</u>
24 FUNERAL DIRECTOR <u>F. Horne 74-12-12-12 Rd</u>		25a REC'D BY REGISTRAR <u>FEB 14 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01733

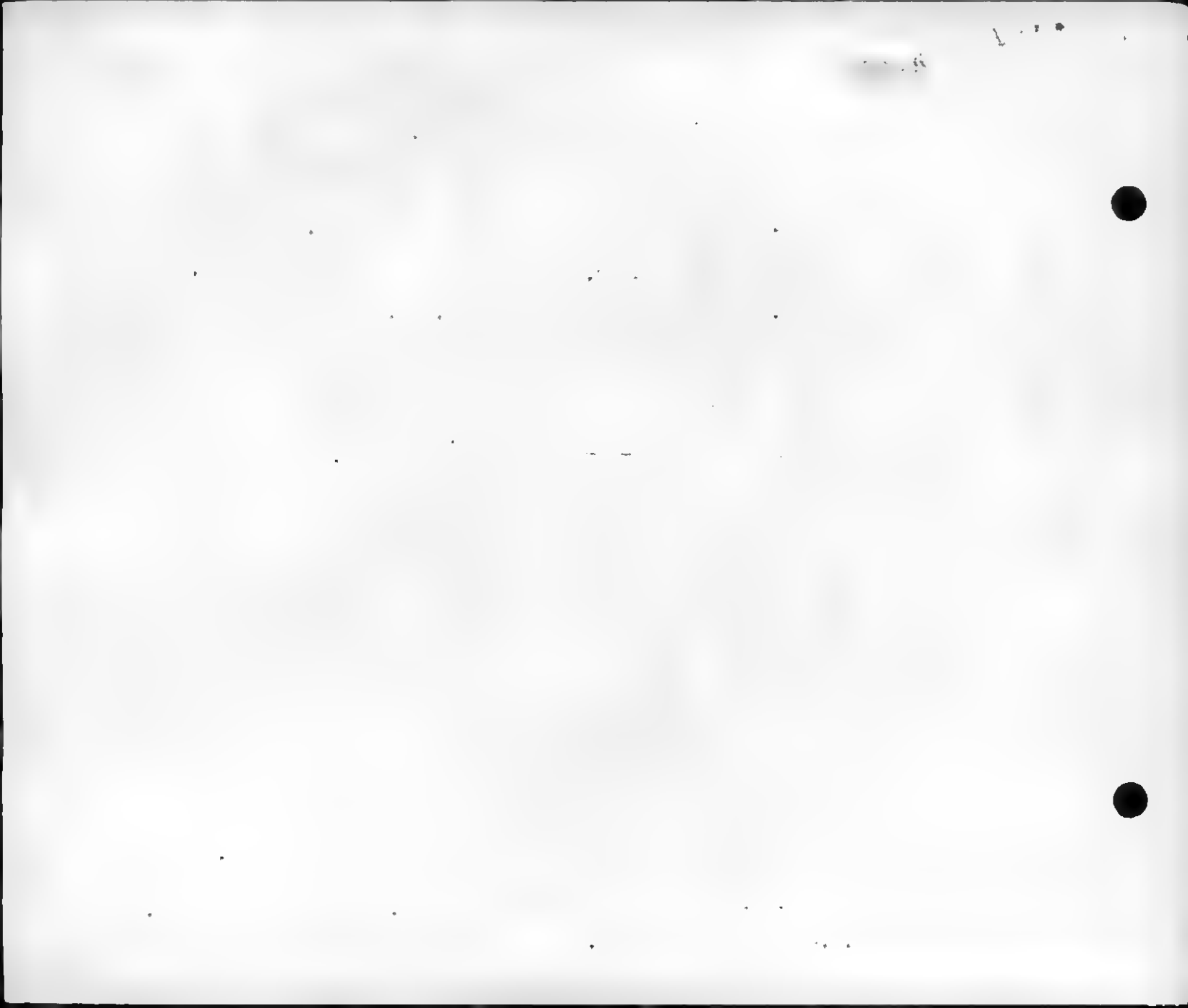
CERTIFICATE OF DEATH

01730

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>23 Dutton Ave.</u>		d. STREET ADDRESS <u>23 Dutton Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Arnold</u> Last <u>Sr.</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug. 15, 1897</u>
9. AGE (In years lost birthday) <u>69</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Richard Arnold</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Frank</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWI</u>		16 SOCIAL SECURITY NO <u>215-12-8108</u>	
17 INFORMANT <u>Mrs. Frank Arnold</u>		Address <u>23 Dutton Ave. - 21228</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 7x11 DUE TO (b) <u>Atherosclerosis of Coronary Vessels</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c) <u> </u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/11</u> , 19 <u>39</u> , to <u>2/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Cliff Ratcliff</u>		22b. DATE SIGNED <u>2/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Cliff Ratcliff</u>		22d. ADDRESS <u>4605 Edmondson Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-21-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24 FUNERAL DIRECTOR <u>Witzke F.D.-4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 20 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



STATE OF MARYLAND

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01731

FOR STATE HEALTH DEPT.

01734

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Baltimore County General Hospital

3. NAME OF DECEASED (Type or print)

Richard S. Ash

5. SEX

Male

6. COLOR OR RACE
White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2/17/1920

4. DATE OF DEATH

Feb. 3, 1967

9. AGE (In years last birthday) 46
IF UNDER 1 YEAR: Months Days Hours Min.
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Reproduction Mgr.

10b. KIND OF BUSINESS OR INDUSTRY

Blue Printing

11. FATHER'S NAME

Richard H. Ash

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Bertha S. Cline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

215-05-8322

Mrs. Alice M. Ash-5 Rolling View Drive

Eldersburg, Md.

16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e)

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)

Increased stress 30-30 caliber rifle & shot himself.

20c. TIME OF INJURY

8:30 a.m. Feb. 3 1967

Month, Day, Year

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

Sykesville

(County)

Carroll

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion

death resulted from Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

D. D. Caples

CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type)

Reisterstown Md.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

2-5-67

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

2/6/67

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

Lake View Memorial Cemetery Liberty Rd.

22d. LOCATION (City, town, or country)

(State)

Md.

23. FUNERAL DIRECTOR

Loring Byers-8728 Liberty Rd. Randallstown, Md.

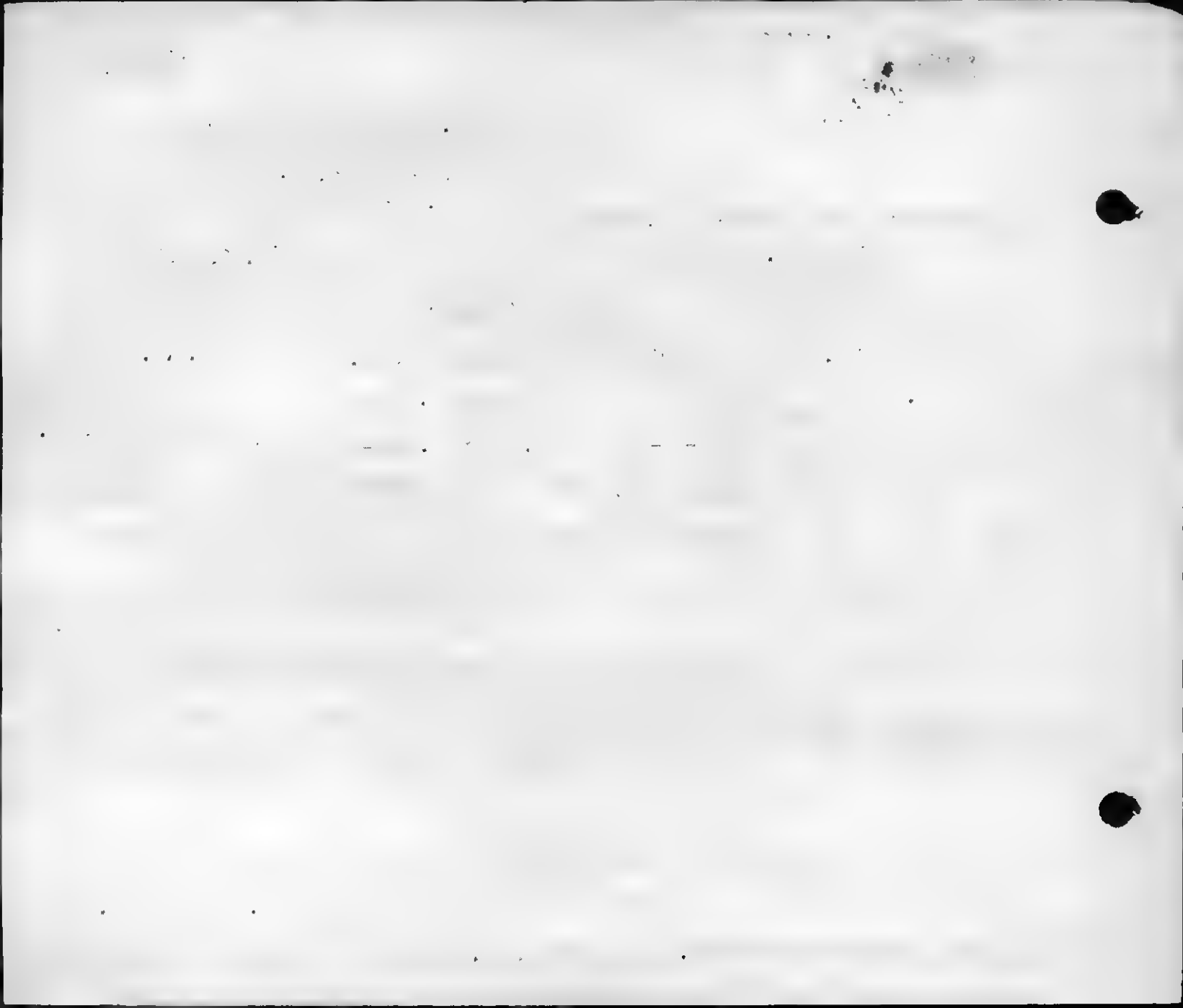
24a. REC'D BY REGISTRAR

DATE FEB 7 1967

24b. REGISTRAR'S SIGNATURE

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. Pages 5 may be retained for your files. NO FUNERAL DIRECTOR: Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

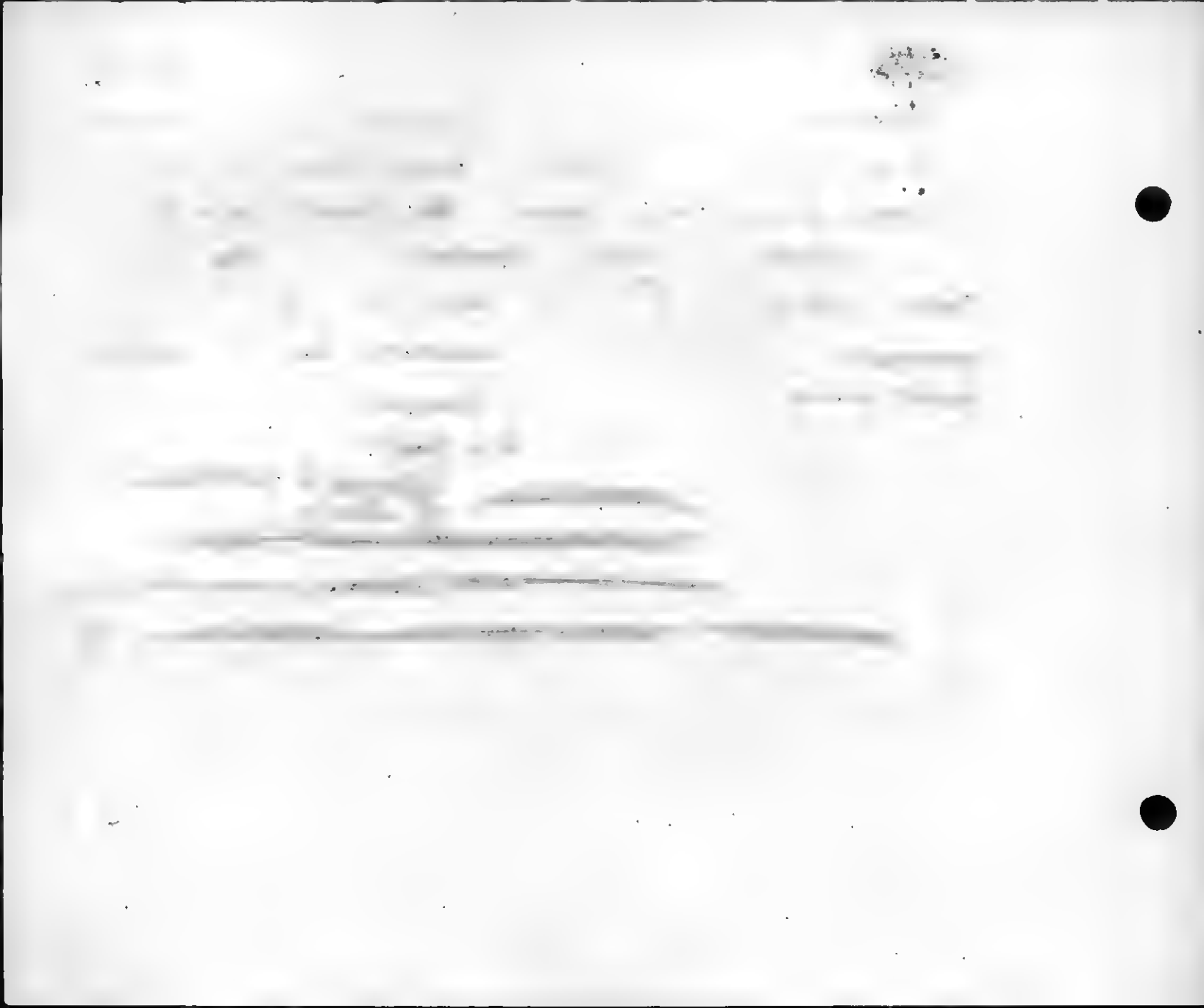
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01735

01732

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON 21204</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTO. MEDICAL CENTER</u>				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON, BALTO, MD. 21204</u>			
f. STREET ADDRESS <u>944 JOLANNEY VALLEY RD.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MILLIAN</u> First		<u>MAY</u> Middle		<u>BARNHARD.</u> Last		4. DATE OF DEATH Month <u>FEB</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-25-95</u>	
9. AGE (in years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>HOUSEMAKER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WOODBIDGE, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT GILLIS</u>				14. MOTHER'S MAIDEN NAME <u>DONNOLLY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>HAROLD BARNHARD.</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laguerre's carcinoma of liver</u> DUE TO (b) <u>Cc of breast and Esophagus</u> DUE TO (c) <u>with extensive metastasis in lung and portal system</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>probably metastasis to brain</u>							
19. INTERVAL BETWEEN ONSET AND DEATH <u>Same as #2</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>67</u> , to <u>Feb 4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Feb 4</u> , 19 <u>67</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>S. e. chang</u>				22b. DATE SIGNED <u>Feb 4 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Seock C. CHANG</u>	
22d. ADDRESS <u>G B M C</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cloverleaf Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Woodbridge, New Jersey</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Maryland 21204</u>				25a. REC'D BY REGISTRAR <u>FEB 6 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>J. J. Judge</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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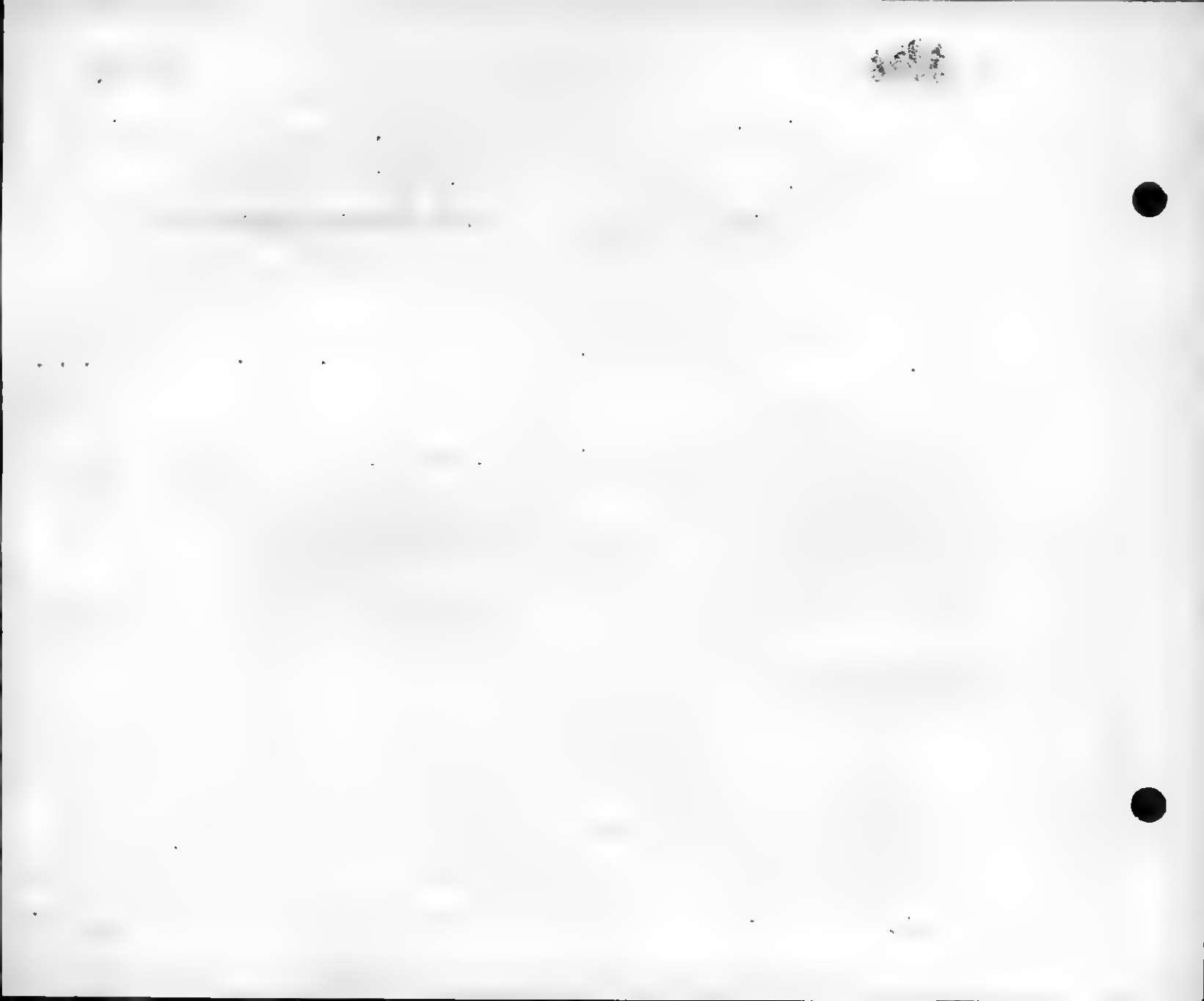
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01736

CERTIFICATE OF DEATH

01733

1. PLACE OF DEATH a. COUNTY: Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. tut. on Residence before admission) a. STATE: Md. b. COUNTY: Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines Catonsville		d. STREET ADDRESS 2648 Maryland Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last John L Barr		4. DATE OF DEATH Month Day Year February 16 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1882
9. AGE (In years lost birthday) 84 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY Refriger Engineer	
11. BIRTHPLACE (County & State, or foreign country) Washington Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Barr		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 234-05-0031A	
17. INFORMANT Mr Preston Barr		Address 5904 Greenhill Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c) 1032' Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2 wks.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 6-24, 1966 , to 2-16, 1967 , that (I) (we) last saw the deceased alive on 2-14, 1967 , and that death occurred at 10 P. M, from causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallagher Sr.		22b. DATE SIGNED 2-17-67	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, Sr.		22d. ADDRESS 6209 Frederick Dr. Balt. 21228, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-20-1967	23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Waynesboro Penna.
24. FUNERAL DIRECTOR Lassala Funeral Home		25a. REC'D BY REGISTRAR DATE FEB 20 1967	
ADDRESS 5401 Belair Road		25b. REGISTRAR'S SIGNATURE Phyllis Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

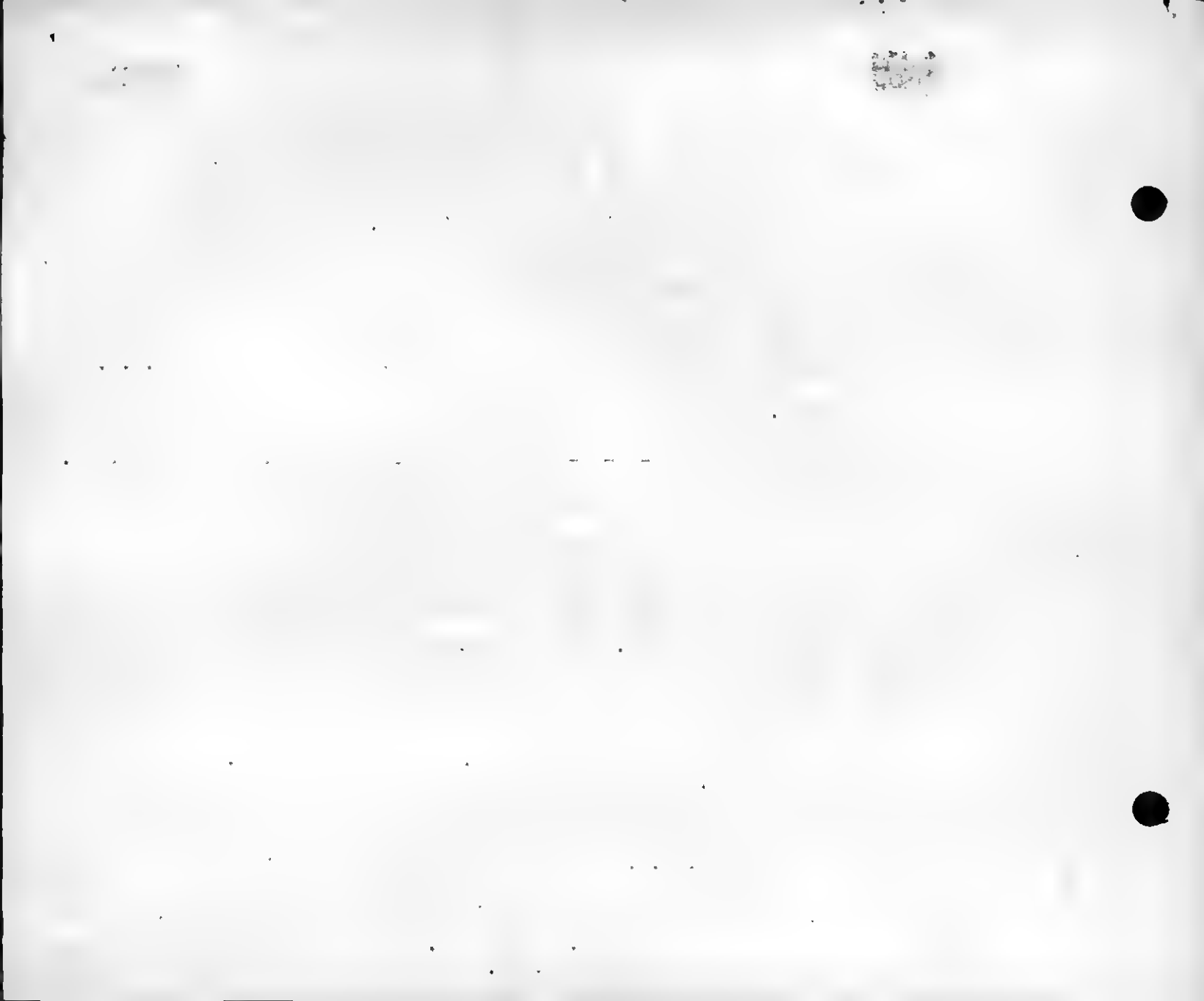
01737

01734

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 55 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS 2446 W. Baltimore Street	
3. NAME OF DECEASED (Type or print) First JOHN Middle ROLAND Last BASS		4. DATE OF DEATH Month FEBRUARY Day 26 Year 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/15
9. AGE (In years last birthday) 51 yrs.		10. IF UNOER 1 YEAR Months 26 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Social Security	
11. BIRTHPLACE (County & State, or foreign country) Norfolk, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN R. BASS		14. MOTHER'S MAIDEN NAME ANNIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO 577-18-46-62	
17. INFORMANT Clinical Records, VAH, Fort Howard, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH WEEKS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NEPHROSCLEROSIS AND UREMIA. DIABETIS MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (th s hospital) attended the deceased from Jan. 3 , 19 67 , to Feb. 26 , 19 67 , that he (we) last saw the deceased alive on Feb. 26 , 19 67 , and that death occurred at 6:40AM from causes and on the date stated above			
22a. SIGNATURE <i>Peter Juvan</i>		22b. DATE SIGNED 2/26/67	
22c. PHYSICIAN'S NAME (Type) PETER JUWAN, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-2-67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR <i>Kelson Funeral Home</i> Kelson Funeral Home		25a. REC'D BY REGISTRAR Charles Judge DATE MAR 1 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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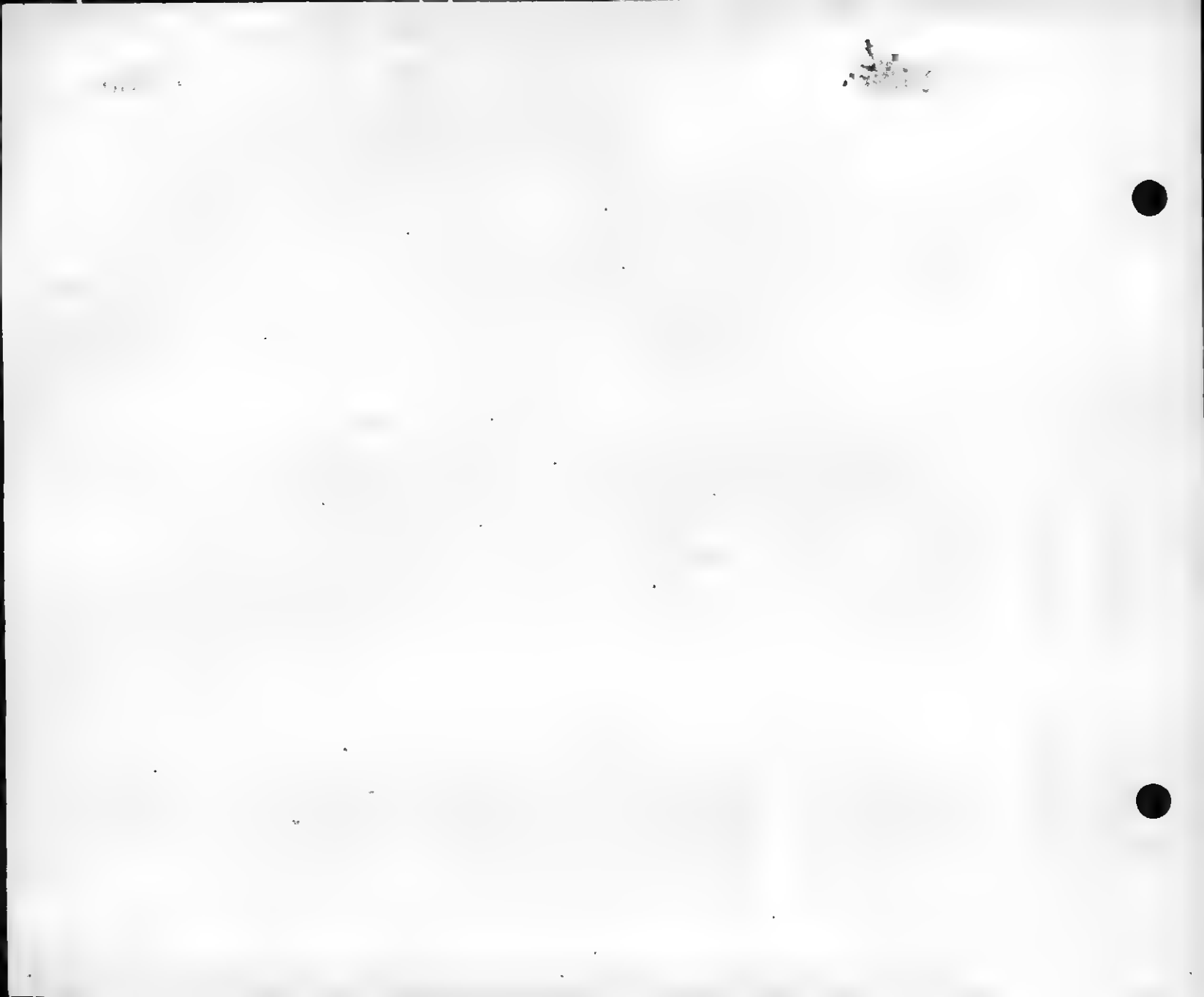
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01738

CERTIFICATE OF DEATH

01735

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> c. LENGTH OF STAY IN 1b <u>30 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Md. Masonic Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admiss an) a. STATE <u>Maryland</u> b. COUNTY <u>1</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>HOPKINS Apartments</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Florence</u> Middle <u>Bayless</u> Last 4. DATE OF DEATH <u>February</u> Month <u>13</u> Day <u>1967</u> Year		5. SEX <u>Fe</u> 6. COLOR OR RACE <u>w</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>October 14, 1892</u> 9. AGE (In years last birthday) <u>74</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Barther + Millams</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John T. Bayless</u> 14. MOTHER'S MAIDEN NAME <u>Anna E. Burke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>220-54-61281</u> 17. INFORMANT <u>Reedney Md. Masonic Homes, Cockeysville</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4 Arteriosclerotic heart disease</u> DUE TO <u>4200</u> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) <u>3 diabetes Mellitus</u> (c) <u>2 Broncho pneumonia</u> (d) <u>Senility</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>65</u> to <u>Feb 13</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Feb 13</u> 19 <u>67</u> , and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Tamshid Hamed MD</u> M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED <u>Feb 13, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>TAMSHID HAMED MD</u> 22d. ADDRESS <u>Masonic Home</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Feb. 15, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u> 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson,</u> ADDRESS <u>1050 York Road Towson, Md. 21204</u> 25a. REC'D BY REGISTRAR <u>DATE FEB 15 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



01739

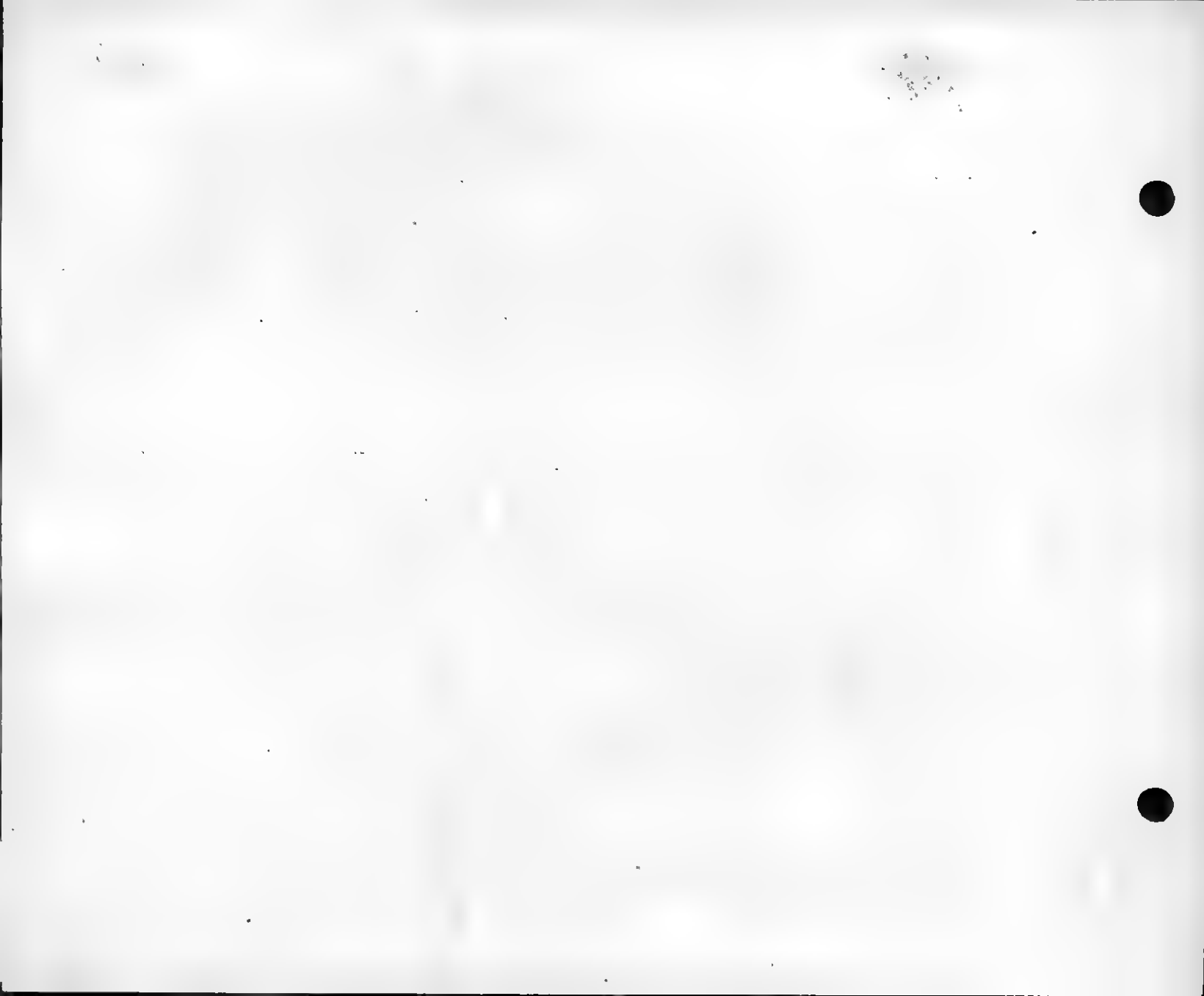
CERTIFICATE OF DEATH

01736

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1941 N. Patterson Park Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
3. NAME OF DECEASED (Type or print) Ruth		First Middle Beste		Last Beste		4. DATE OF DEATH Month February Day 16 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 18, 1893	9. AGE (in years last birthday) 73 y/s	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thatcher Bell				14. MOTHER'S MAIDEN NAME Laura Chilcote			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-12-7757		17. INFORMANT Address Mrs. Mary Nelson-3201 Glendale Ave.-21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Respiratory arrest DUE TO (b) Cerebral hemorrhage DUE TO (c) Hypertension						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 04 (this hospital) attended the deceased from 2/7/ , 1967, to 2/16/ , 1967, that 04 (we) last saw the deceased alive on 2/16/ , 1967, and that death occurred at 8:25 M, from causes and on the date stated above.							
22a. SIGNATURE <i>Jaime Singzon</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED February 16, 1967			
22c. PHYSICIAN'S NAME (Type) Jaime Singzon, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL (CREMATION, REMOVAL) (Specify) Burial		23b. DATE THEREOF 2-20-67		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road-21206		25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REG STRAHS SIGNATURE <i>William J. Judge</i>			

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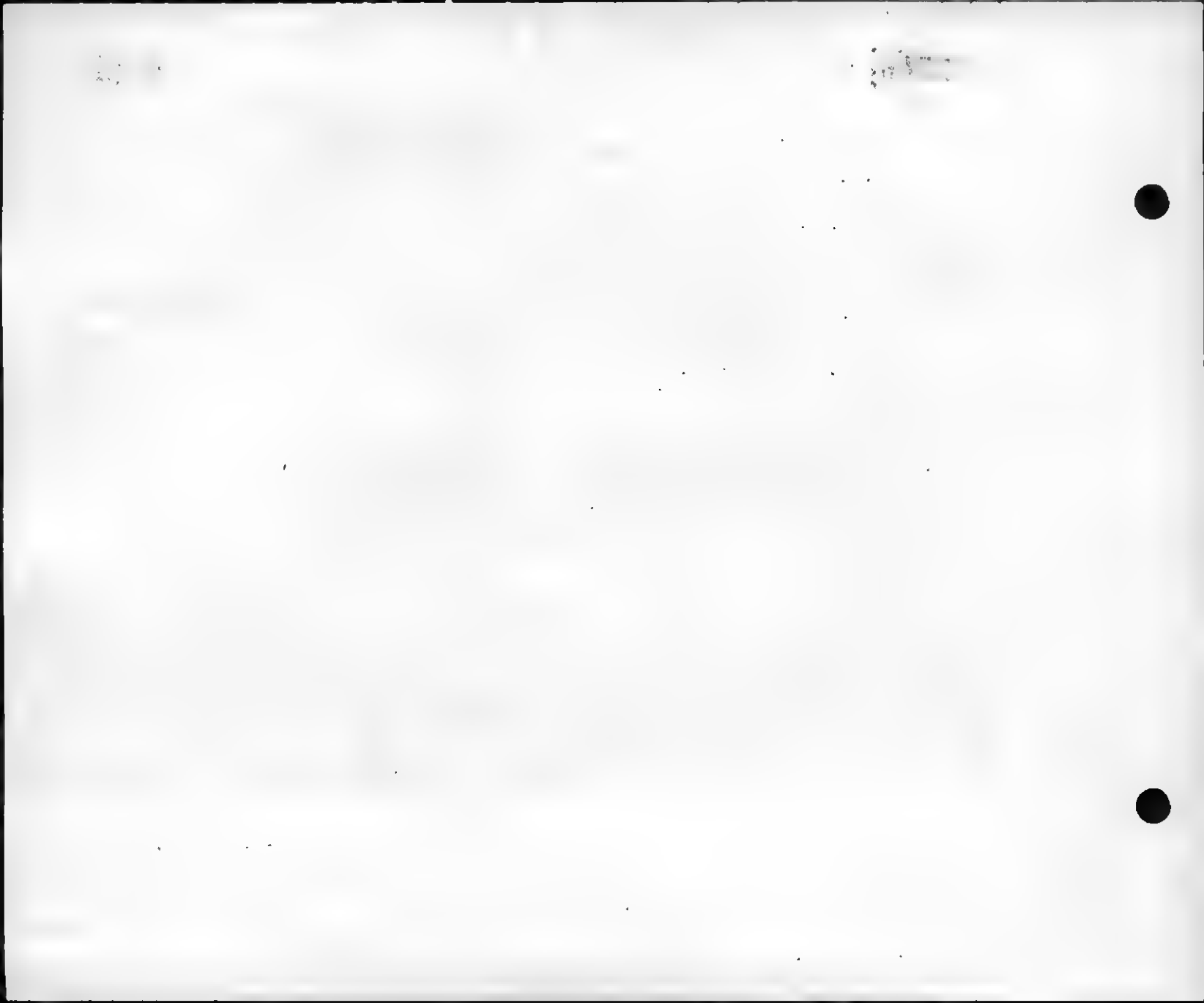
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01740

CERTIFICATE OF DEATH

01737

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> COUNTY <u>Cecilia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY in 1b <u>8 mo. 16 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>George FRANKLIN BINES Sr.</u>		4 DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 7 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Bines</u>		14. MOTHER'S MAIDEN NAME <u>SARAH Boyd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>717-07-5522</u>	
17. INFORMANT <u>Records: Spring Grove State Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO (b) <u>Decubitus Ulcer</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 22, 1966</u> to <u>Feb. 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb. 9, 1967</u> , and that death occurred at <u>5:40 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ferdinand Massari</u> M.D.		22b. DATE SIGNED <u>2/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FERDINAND MASSARI</u>		22d. ADDRESS <u>Spring Grove State Hospital Baltimore, Md. 21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2/12-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Principis Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 17 1967</u>	



01741

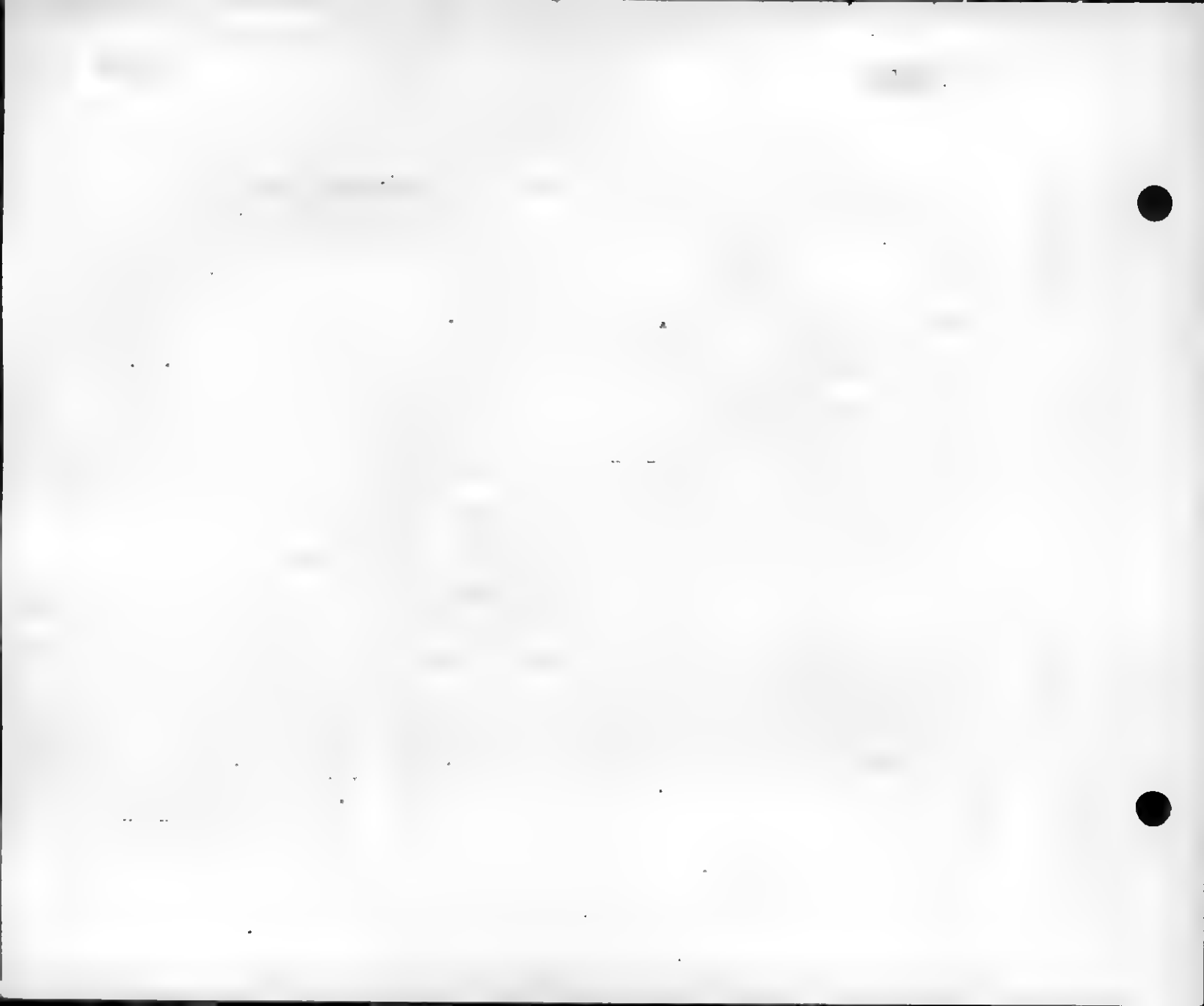
CERTIFICATE OF DEATH

01738

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr4mth6dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Olga Middle Binkley Last Binkley		4. DATE OF DEATH Month February Day 11 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1886
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Henry Olyann		14. MOTHER'S MAIDEN NAME Minnie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-03-5070D	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4101 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from Oct. 5, 1864 to Feb. 11, 1967 , that he (we) last saw the deceased alive on Feb. 11, 1967 , and that death occurred at 8:30 M, from causes and on the date stated above.			
22a. SIGNATURE Narciso W. Carmona M.D.		22b. DATE SIGNED 2-11-67	
22c. PHYSICIAN'S NAME (Type) Narciso W. Carmona		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/23/67	23c. NAME OF CEMETERY OR CREMATORY Louisa PK Cem	23d. LOCATION (City or Town) (County) (State) BALTO Md
24. FUNERAL DIRECTOR E. S. Mac Nabb Catonsville 28 Md		25. REC'D BY REGISTRAR Feb 24 1967	
25b. REGISTRAR'S SIGNATURE for [Signature]			



FOR STATE
HEALTH DEPT.

01742

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01739

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General Hospital		d. STREET ADDRESS Route 2	
3 NAME OF DECEASED (Type or print) First Stewart Middle M. Last BLAIR		4. DATE OF DEATH Month February Day 12, Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1906
9 AGE (in years last birthday) 60 yrs		IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance MAN		10b. KIND OF BUSINESS OR INDUSTRY Water Supply City	
11 BIRTHPLACE (State or foreign country) N. C.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Lee BLAIR		14 MOTHER'S MAIDEN NAME Emma Matheson	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. ?	
17. INFORMANT Mrs. Mary Blair - Rt. 2 Finksburg, Md.		Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive pulmonary emboli complicating fracture of left patella Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of truck which struck another truck in rear Fractured left knee cap on job	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:30 pm 1-10 1967	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) work Highway	20f. (City or town) (County) (State) Baltimore Md
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from. Not a natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED February 13, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2-16-67	23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery	23d. LOCATION (City or Town) (County) (State) Carroll Co. Md.
24. FUNERAL DIRECTOR Harry W. Knight		25. REC'D BY REGISTRAR FEB 20 1967	
ADDRESS Sykesville, Md		26. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

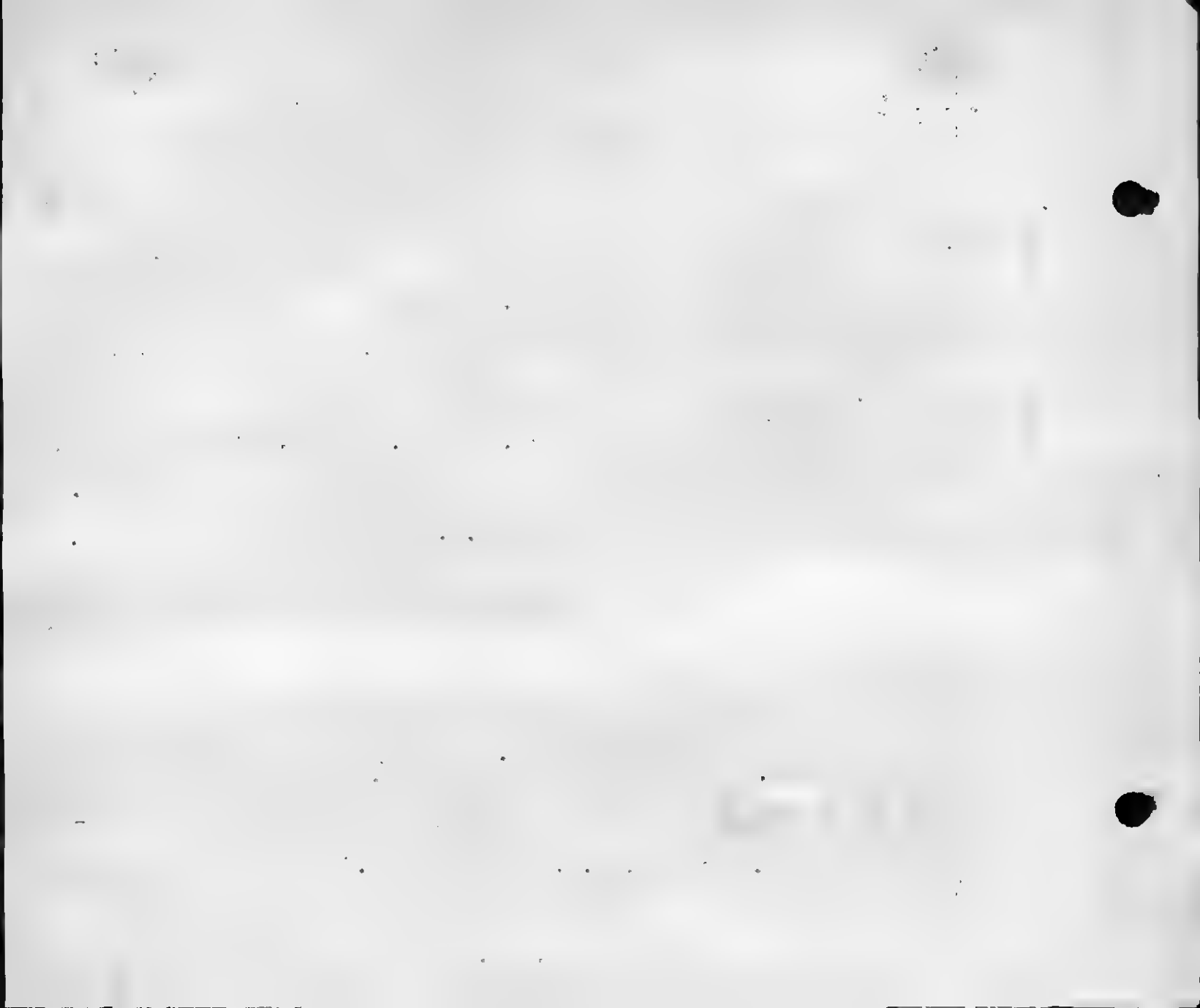
01743

CERTIFICATE OF DEATH

01740

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>19 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>14 Morrisway Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> d. STREET ADDRESS <u>14 Morrisway Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> <u>HENRY</u> <u>BOECKER</u>		4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>1967</u>									
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1923</u>								
9. AGE (In years last birthday) <u>43</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Canvas Salesman</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10b. KIND OF BUSINESS OR INDUSTRY <u>F.M. Stevenson</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>									
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles C. Roecker</u>									
14. MOTHER'S MAIDEN NAME <u>Regina A. Dumlér</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>									
16. SOCIAL SECURITY NO. <u>216-18-9273</u>		17. INFORMANT <u>Mrs. Doris L. Boecker</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerotic C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>4 yrs.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 2, 1953</u> to <u>February 6, 1967</u> that (I) (we) last saw the deceased alive on <u>Dec. 1, 1966</u> and that death occurred at <u>10 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Martin E. Strobel</u>		22b. DATE SIGNED <u>2-8-67</u>									
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>		22d. ADDRESS <u>48 Main St. Reisterstown, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens</u>	23d. LOCATION (City, town or county) (State) <u>Finksburg, Maryland</u>								
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Eichhardt</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>DATE FEB 10 1967</u> <u>J. M. Jones, Judge</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01744

CERTIFICATE OF DEATH

01741

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b Summitt Nursing Home		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4624 Belair Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MARIA Middle C. Last BOGNANNI		4 DATE OF DEATH Month Feb. Day 7, Year 19 67	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/18/82
9 AGE (In years last birthday) 84 yrs		10 UNDER 1 YEAR Months 5 Days 4 Hours 15 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coat Felter		10b. KIND OF BUSINESS OR INDUSTRY Dvorak Bros.	
11 BIRTHPLACE (County & State, or foreign country) Italy		12 CITIZEN OF WHAT COUNTRY? Italy ✓	
13. FATHER'S NAME Bayli		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. 216-02-2907	
17. INFORMANT Josephine Udes, dght, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs-	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 7/26/66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/26/66 to 2/7/67 , that (I) (we) last saw the deceased alive on 2/9/67 , and that death occurred at 1230 AM from causes and on the date stated above			
22a. SIGNATURE Dr. W. E. McGrath		22b. DATE SIGNED 2/8/67	
22c. PHYSICIAN'S NAME (Type) Dr. W. E. McGrath		22d. ADDRESS 1903 Frederick Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/67	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25a. REC'D BY REGISTRAR FEB 10 1967	
25b. REGISTRAR'S SIGNATURE 3331 Brehms Lane		25c. REGISTRAR'S SIGNATURE 3331 Brehms Lane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3-2-1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

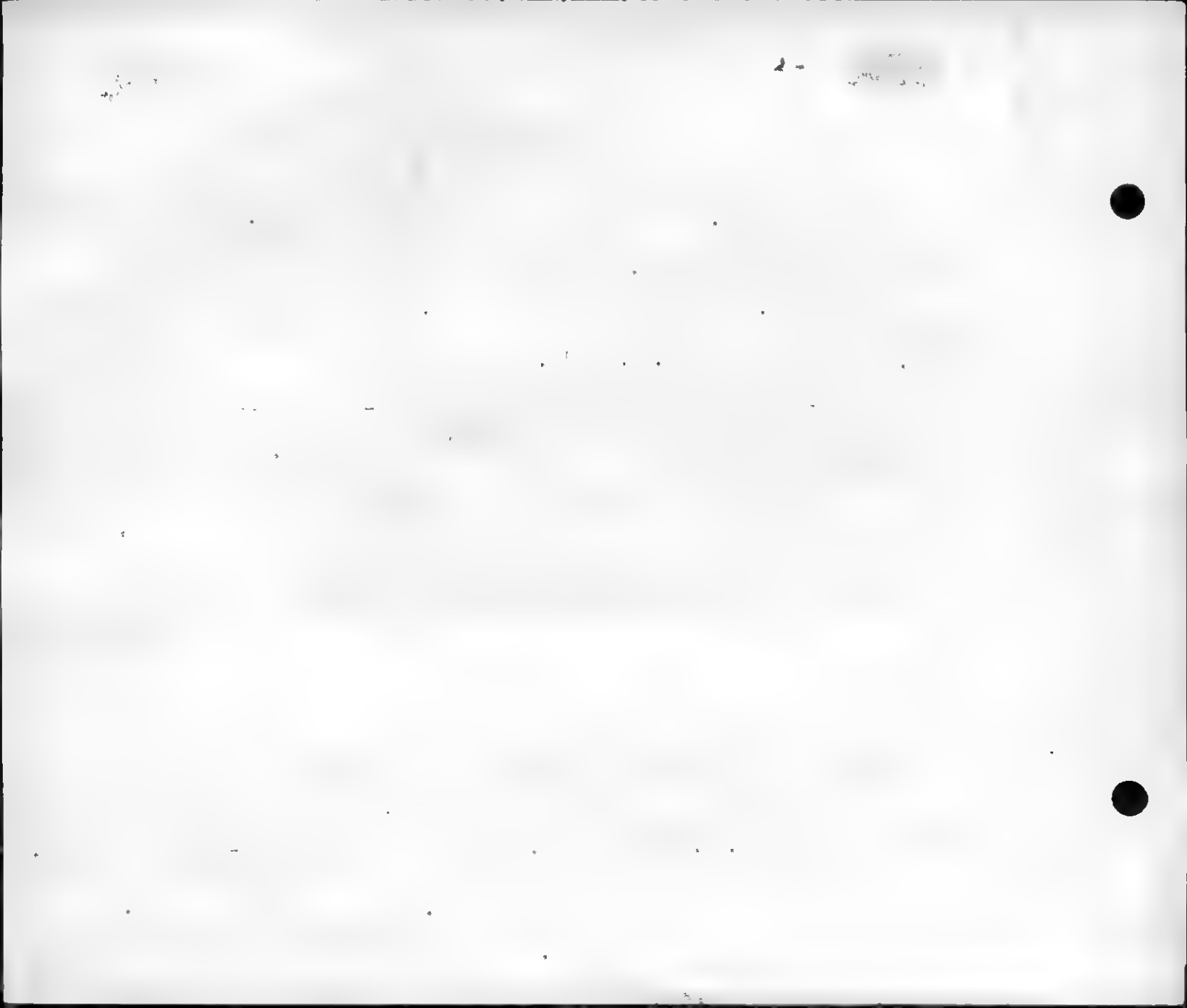
01745

CERTIFICATE OF DEATH

01742

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b Catonsville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 292 Bloomsbury Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Catonsville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 292 Bloomsbury Ave. e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William O. Bomberger		4. DATE OF DEATH Month Day Year Feb. 26, 1967	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1900
9. AGE (In years lost birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Accountant		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late - Arthur Bomberger		14. MOTHER'S MAIDEN NAME Late - Frances ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Clara Bomberger 292 Bloomsbury Ave. - Apt. B-9		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X CARDIAC ARREST. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMATOSIS (c) CARCINOMA, LUNG.		INTERVAL BETWEEN ONSET AND DEATH 4 MO. 15 MO.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (th) s hospital) attended the deceased from 10-18 , 19 67 , to 2-26 , 19 67 , that (I) (we) last saw the deceased alive on 2-10 , 19 67 and that death occurred at 11:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Peter V. B. Thorpe		22b. DATE SIGNED 2-27-67	
22c. PHYSICIAN'S NAME (Type) Peter V. B. Thorpe, M. D.		22d. ADDRESS 409 Columbia Pike-Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-2-67	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR FEB 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G 305 2' 167 jml

CERTIFICATE OF DEATH

01746

01743

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY GEN. HOSP.</u>		d. STREET ADDRESS <u>615 N. KENWOOD AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AUGUSTA B. BOOTH</u>		4. DATE OF DEATH Month Day Year <u>2-2-1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/7/1883</u>
9. AGE (In years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN NEUBERT</u>		14. MOTHER'S MAIDEN NAME <u>SOPHIA GARDNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>CHART</u>		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA & POSSIBLE OVA</u> DUE TO <u>2010</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>LEUKEMIA, Lymphatic Chronic</u> DUE TO (c) <u>THROMBOCYTOPENIA</u>		INTERVAL BETWEEN ONSET AND DEATH
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PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (F EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)
20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> , 19 <u>67</u> , to <u>2/2</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2/2</u> , 19 <u>67</u> , and that death occurred at <u>6:51</u> AM, from causes and on the date stated above.		
22a. SIGNATURE <u>Mariano A. Plentino</u>	22b. DATE SIGNED <u>2/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARIANO A. PLENTINO</u>	22d. ADDRESS <u>1537 SUMMIT AVE. BALT, MD.</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2-6-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>BALTO. MD.</u>
24. FUNERAL DIRECTOR <u>Hartley Miller Mountford & Jefferson St.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

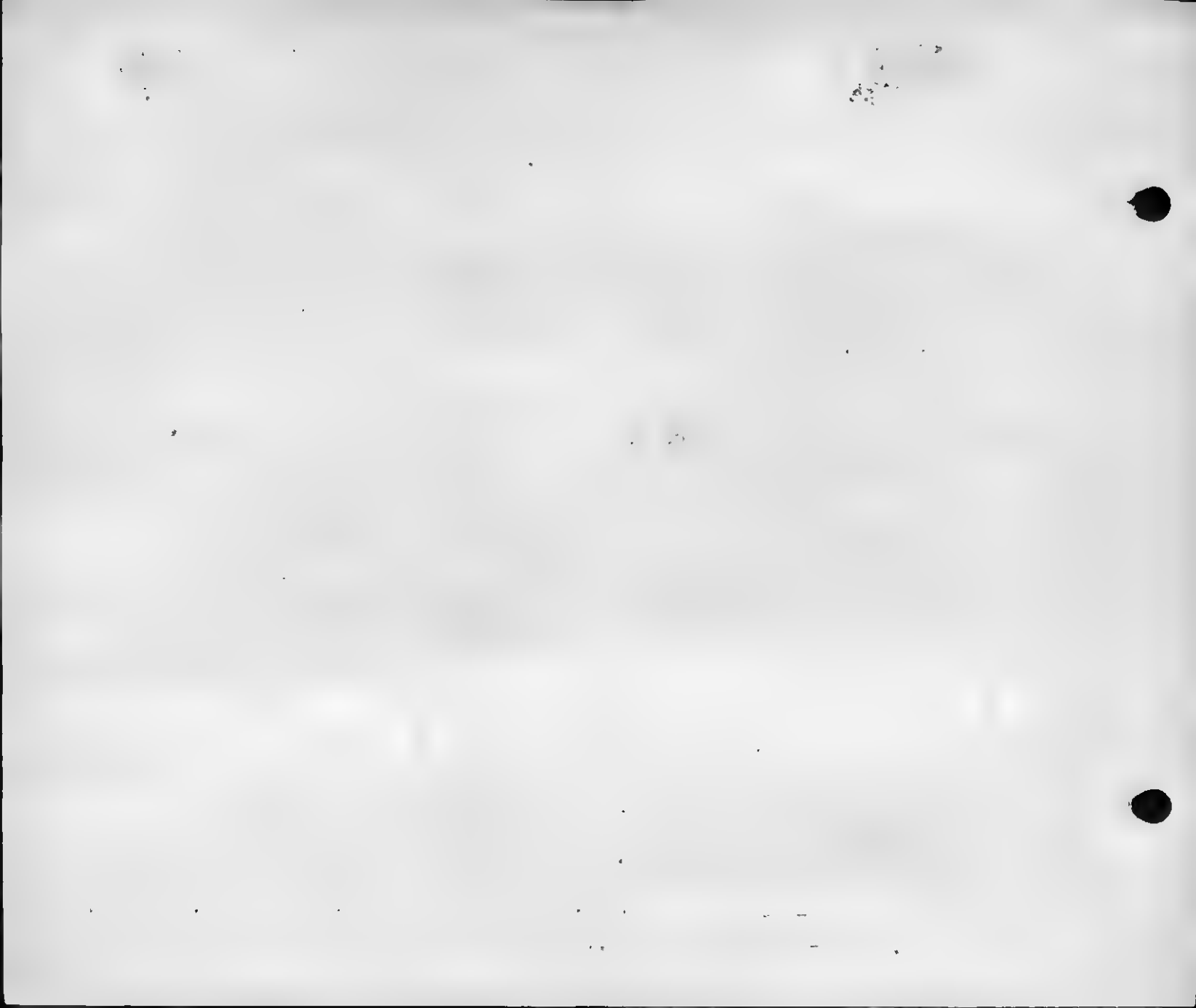
01747

CERTIFICATE OF DEATH

01744

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 14</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>				d. STREET ADDRESS <u>Hillennwood(2019) Road 14</u>			
3. NAME OF DECEASED (Type or print) <u>Henry R. Borig</u>				4. DATE OF DEATH Month <u>01</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/12/1887</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Balto. Trans. Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Richard Borig</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Sterner</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>215-09-3775</u>				17. INFORMANT <u>Records Stella Maris Hospice</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO <u>ASCD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Generalized Ca</u> DUE TO <u>Generalized Ca</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> <u>at work</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>April 10, 1967</u> to <u>2-14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-12</u> , 19 <u>67</u> , and that death occurred at <u>3:20</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert J. Mahon</u>				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>Robert J. Mahon, M.D.</u>				22d. ADDRESS <u>204 E. Joppa Road</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-17-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>				25a. REC'D BY REGISTRAR <u>4001 Ritchie Hgwy., Baltimore</u>			
25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>				DATE <u>FEB 17 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01748

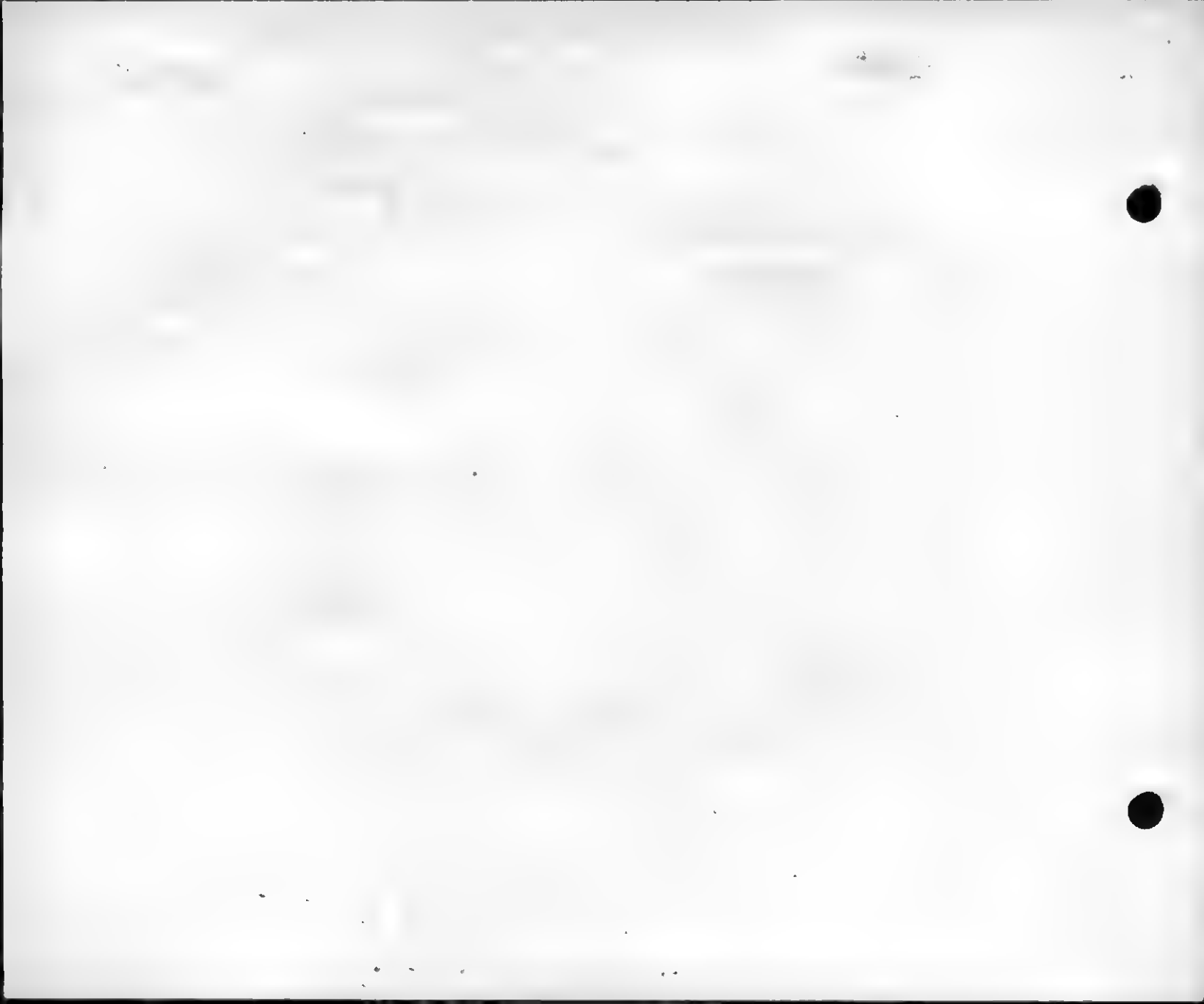
CERTIFICATE OF DEATH

01745

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 'b' <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Milford Manor Nursing Home</u>		d. STREET ADDRESS <u>3418 Ripple Road #7</u>	
3. NAME OF DECEASED (Type or print) First <u>MATHILDE</u> Middle <u>BORRIS</u> Last		4. DATE OF DEATH <u>February 10,</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years lost birthday) yrs. <u>87</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Oppenheimer</u>		14. MOTHER'S MAIDEN NAME <u>Rosa ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>No</u>	
17. INFORMANT <u>Mr. Gunther Borris, 3418 Ripple Road #7</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO <u>Coronary Thrombosis - General</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO <u>(Age)</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Abdominal Tumor c. Obstruction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>15 years</u> to <u>2/10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> 19 <u>67</u> , and that death occurred at <u>6 p.m.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Kurt Levy, M.D.</u>		22b. DATE SIGNED <u>2/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Kurt Levy, 3103 North Charles Street</u>		22d. ADDRESS <u>3103 North Charles Street</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cheverre Ahavas Chessed</u>	23d. LOCATION (City or Town) (County) (State) <u>Randallstown, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01749

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01746

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN TB 11 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2522 McComas Ave.		2 USUAL RESIDENCE (Where deceased lived if not in residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Dundalk d. STREET ADDRESS 2522 McComas Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Minnie Middle Bosley Last Bosley 4 DATE OF DEATH Month February Day 2 Year 19 67		5 SEX Female 6 COLOR OR RACE White 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH 2/14/84 9 AGE (In years last birthday) 82 FUNDER 1 YEAR Months 2 Days 19 Hours 67 IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY New York 11. BIRTHPLACE (State or foreign country) U. S. A. 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Henry Pfort 14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO 215-54-1878 17. INFORMANT (Husband) Abram W. Bosley, 2522 McComas Ave. Dundalk, Address Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-DISEASE 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Senility DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Melvin B. Davis M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6800 Mornington Rd. Dundalk, Md. 21222	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/6/67 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery 23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		25a. REC'D BY REGISTRAR FEB 1967 25b. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the margin. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

Item 20 Film 385 2-14-67

01750

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01747

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>M.</u> Last <u>Bowerman</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>19 67</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-1888</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
10a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		10b. CITIZEN OF WHAT COUNTRY? <u>US</u>	
11. FATHER'S NAME <u>Francis P. Oates</u>		12. MOTHER'S MAIDEN NAME <u>Margaret E. Harlon</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. SOCIAL SECURITY NO. <u>216464035</u>	
15. INFORMANT <u>J. Edwin Oates</u>		Address <u>103 Spring side Drive</u>	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vascular Collapse</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell on floor of home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11:30</u> p.m. <u>Dec 27 19 66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Balto. City</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		22. DATE SIGNED <u>1/6/67</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		Address (Street, city, town, or county) <u>7501 York Rd. Balto. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>2-9-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Kuck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>---</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01751

01748

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 20 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTRE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last JOSEPH THOMAS BOWERS		4 DATE OF DEATH Month Day Year FEB. 21 1967	
5 SEX M	6. COLOR OR RACE Can.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3.19.1902
9. AGE (In years last birthday) 65 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETI.		10b. KIND OF BUSINESS OR INDUSTRY POST OFFICE	
11. BIRTHPLACE (County & State, or foreign country) PHILADELPHIA, PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL H. BOWERS		14. MOTHER'S MAIDEN NAME TEIPEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 224-60-1204	
17. INFORMANT Patient's Chart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastases DUE TO Carcinoma Prostate Gland Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from FEB 20, 1967 to FEB 21, 1967 , that (I) (we) last saw the deceased alive on FEB 21st 1967 , and that death occurred at 6:00 AM , from causes and on the date stated above.			
22a. SIGNATURE M. I. Mac Gregor M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 2-21-67
22c. PHYSICIAN'S NAME (Type) M. I. Mac Gregor		22d. ADDRESS Greater Baltimore Med. Centre	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/24/67	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md
24. FUNERAL DIRECTOR E. S. MacNabb		ADDRESS 301 Frederick Rd, Balt. 21208 Md	25a. REC'D BY REGISTRAR DATE FEB 24 1967
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

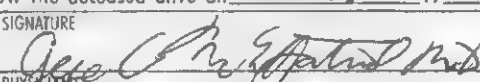
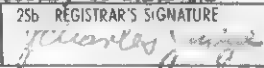
01752

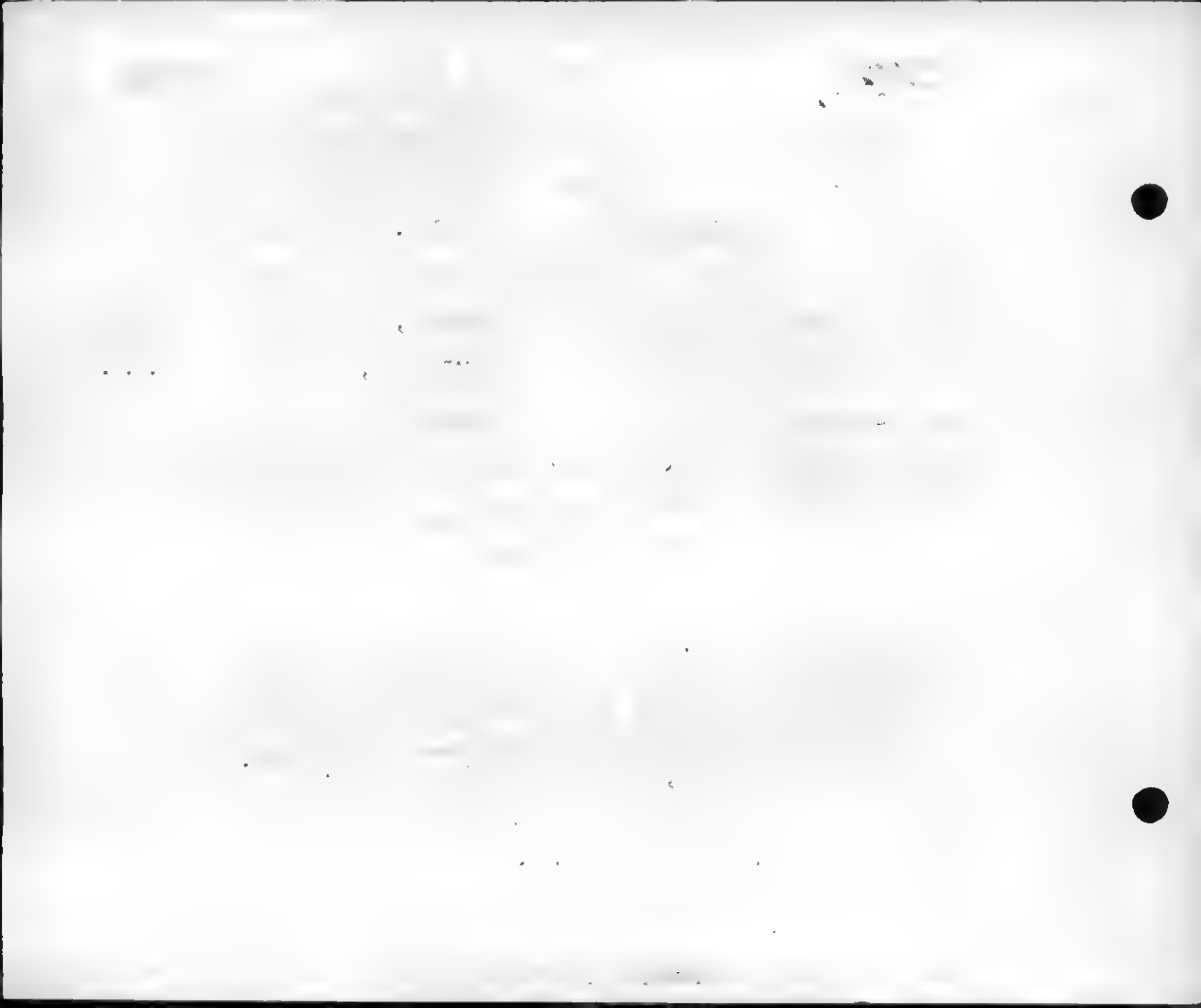
CERTIFICATE OF DEATH

01749

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD,			c. LENGTH OF STAY IN 1b 245 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 671 S. WICKHAM ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CHRISTIAN BRANDT				4. DATE OF DEATH Month Day Year FEBRUARY 15 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCTOBER 8, 1893		9. AGE (In years last birthday) yrs 73	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPEFITTER			10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FREDERICK BRANDT				14. MOTHER'S MAIDEN NAME MARY DAUM			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI			16. SOCIAL SECURITY NO 218 03 83 97		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) LAENNEC'S CIRRHOSIS DUE TO (c) UNKNOWN							INTERVAL BETWEEN ONSET AND DEATH 6 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CARCINOMA OF PROSTATE. POST OPERATIVE REMOVAL OF MENINGIOMA							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 17, 1966 , to FEB. 15, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEB 15, 1967 , and that death occurred at 551A M, from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED 2/15/67		22c. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/17/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR AMBROSE FUNERAL HOME ARBUTUS, MARYLAND				25a. REC'D BY REGISTRAR FEB 20 1967		25b. REGISTRAR'S SIGNATURE 	



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MARYLAND STATE DEPARTMENT OF HEALTH

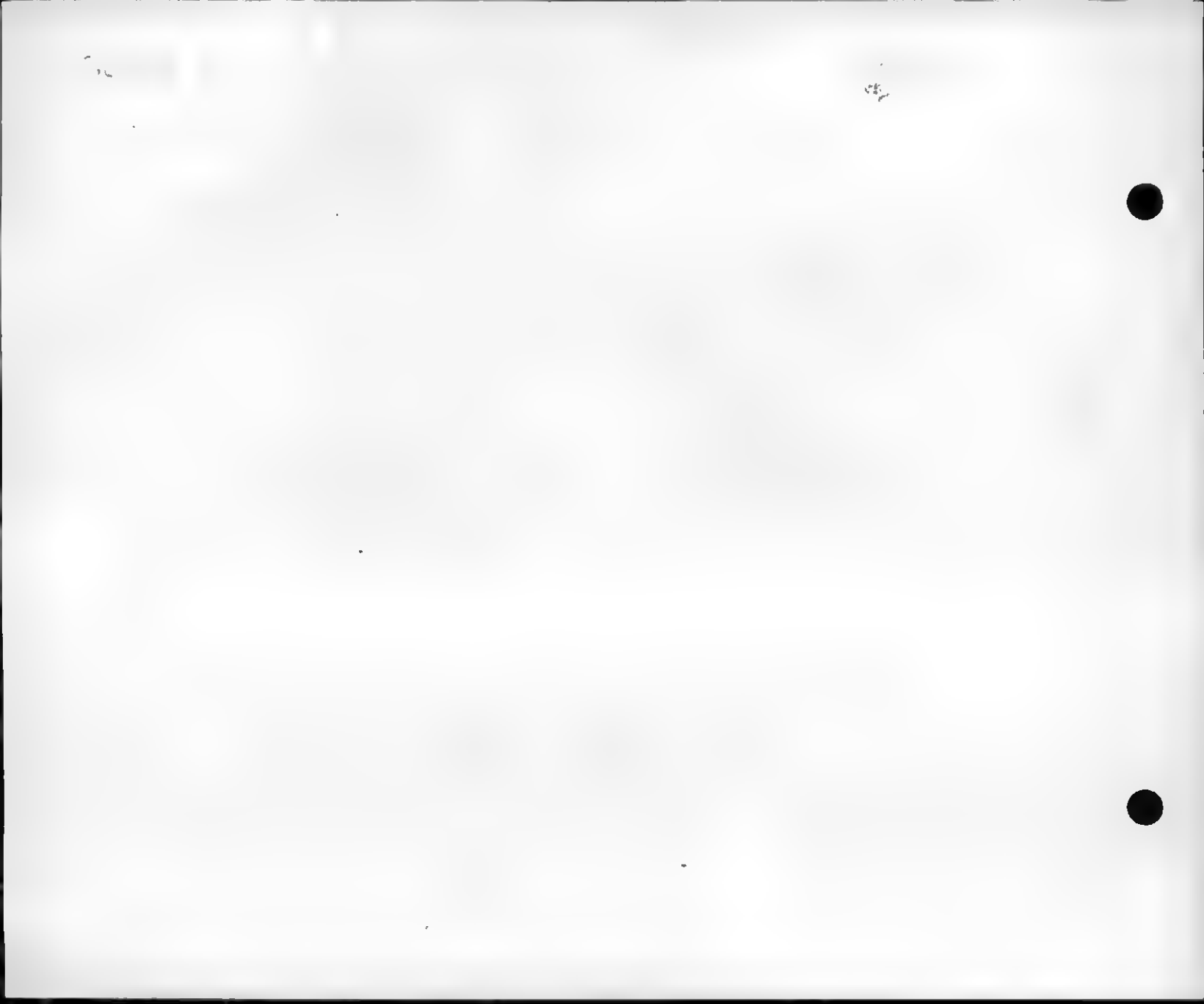
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01753

CERTIFICATE OF DEATH

01750

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9755 MagLeet Rd</u>				d. STREET ADDRESS <u>9755 MagLeet Rd</u>			
3. NAME OF DECEASED (Type or print) <u>ALphonse J. BRAUN</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>10</u> Year <u>67</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26-1886</u>	9. AGE (in years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours <u>67</u> Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland - BALTO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John P. BRAUN</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine E. Ruth</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>217-36-3788</u>				17. INFORMANT <u>MINNIE BRAUN</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intersecting Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last, (c) <u>with myocardial degeneration</u> DUE TO <u>with myocardial degeneration</u> DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Coronary Artery Disease, Prostatic Hypertrophy</u>							19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month <u>Jan</u> Day <u>19</u> Year <u>1967</u> Hour a.m. <u>2</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Fulton Md</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> to <u>Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 7 1967</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank J. Kasik</u>				22b. DATE SIGNED <u>2/11/67</u>		22c. PHYSICIAN'S NAME (Type) <u>FRANK J. KASIK</u>	
22d. ADDRESS <u>9005 Hartford Rd</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
23b. DATE THEREOF <u>2-13-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST Joseph</u>		23d. LOCATION (City, town or county) (State) <u>Fulton Md</u>			
24. FUNERAL DIRECTOR <u>Chas. F. Evans & Son</u>				25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01754						01751					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Baltimore Co.</u>			MARYLAND			a. STATE <u>Md.</u>			b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						d. STREET ADDRESS <u>Vernon Rd - Box-22c</u>					
3. NAME OF DECEASED (Type or print) <u>Baby First Girl Bridges</u>						4. DATE OF DEATH Month <u>2</u> Day <u>23</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-17-67</u>		9. AGE (In years last birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cube</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co., Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Edward Bridges</u>						14. MOTHER'S MAIDEN NAME <u>Sara Katherine Saunders</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Admission (Birth Information) Chart</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concealed heart disease - myogenic (interventricular septal defect)</u> DUE TO (b) <u>Concealed heart disease - myogenic (interventricular septal defect)</u> DUE TO (c) <u>Concealed heart disease - myogenic (interventricular septal defect)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Osseophalocoele</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-17-</u> , 19 <u>67</u> , to <u>2-23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-22</u> , 19 <u>67</u> , and that death occurred at <u>4:50 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Christine Simon</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>2-23-67</u>		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>Feb. 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Vernon Methodist Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>White Hall, Maryland</u>			
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>						25a. REC'D BY REGISTRAR <u>FEB 27 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MEDICAL CERTIFICATION

1942



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VR A15 (4)
25M 1/67

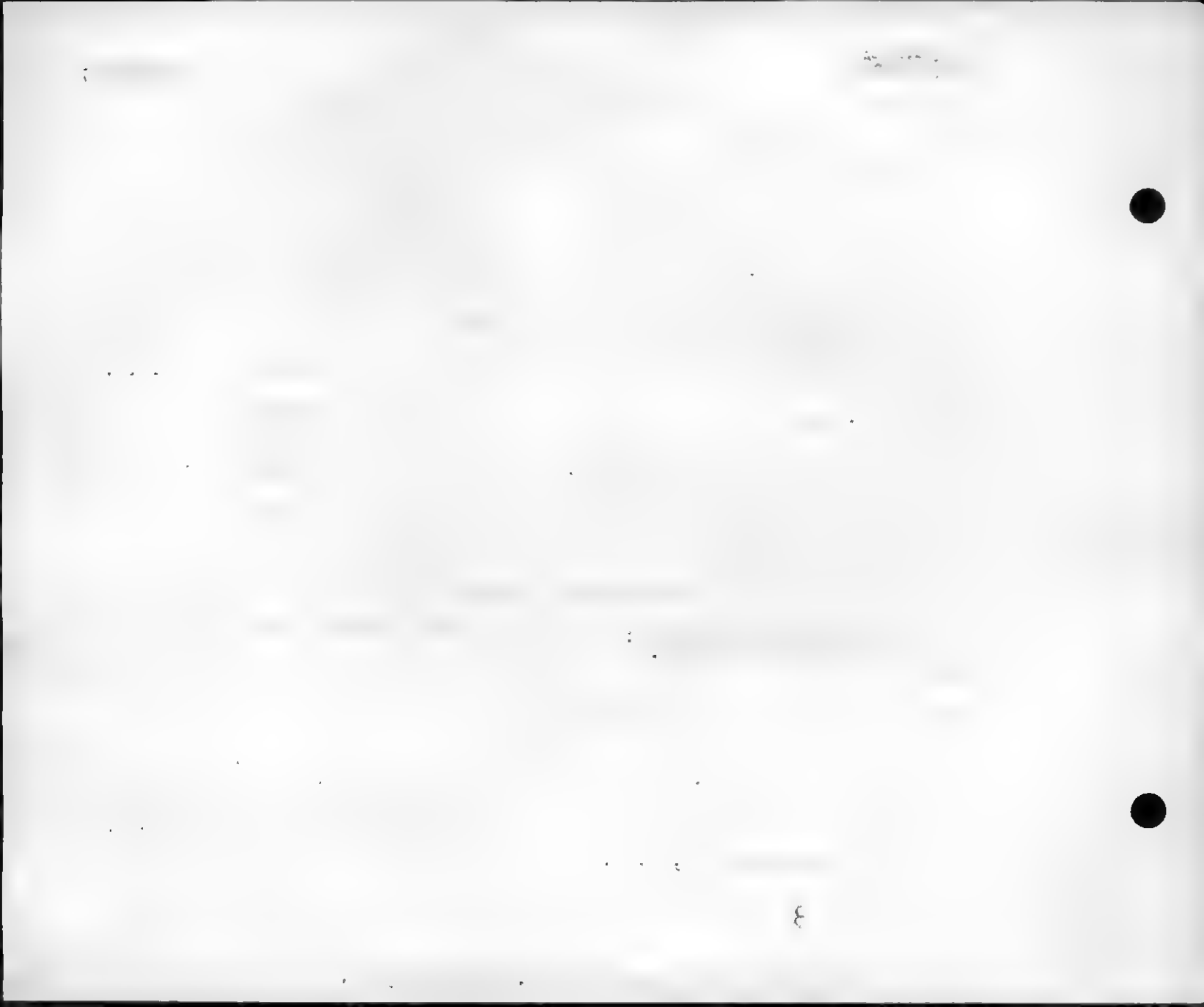
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01755

CERTIFICATE OF DEATH

01752

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 4 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission a. STATE MARYLAND b. COUNTY BALTIMORE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 928 NORTH MADEIRA STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First GEORGE Middle EDWARD Last BRIGHT		4 DATE OF DEATH Month FEBRUARY Day 27 Year 19 67					
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10 17 96	9 AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Mm	IF UNDER 24 HRS Months Days Hours Mm	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIRER		10b. KIND OF BUSINESS OR INDUSTRY BRASS FOUNDRY		11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME GEORGE E. BRIGHT				14 MOTHER'S MAIDEN NAME Sophie Oberlander			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-1		16 SOCIAL SECURITY NO 217 01 30 96		17 INFORMANT CLIN REC VET ADM HOSP FT HOWARD MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <input checked="" type="checkbox"/> IMMEDIATE CAUSE (a) PULMONARY EMBOLUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <input checked="" type="checkbox"/> (b) DO NOT <input type="checkbox"/> (c) MALNUTRITION, DEHYDRATION						INTERVAL BETWEEN ONSET OF DEATH YEARS	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL ARTERIOSCLEROSIS; OLD FRACTURE LEFT FEMORAL NECK; HIPS CONTRACTURES; DECUBITUS.						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Feb. 23 , 19 67 , to Feb. 27 , 19 67 , that (X) (we) last saw the deceased alive on Feb. 27 , 19 67 , and that death occurred 3:30 a.m. from causes and on the date stated above.							
22a. SIGNATURE Neilson Neilson				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/27/67	
22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-2-67		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER Cemetery		23d. LOCATION (City or town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Philip F. Leach		ADDRESS CVACH FUNERAL HOME MONUMENT ST. BALTIMORE, MD.		25a. RECD BY REGISTRAR MAR 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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VR A15 (4)
15M 4-64

01756

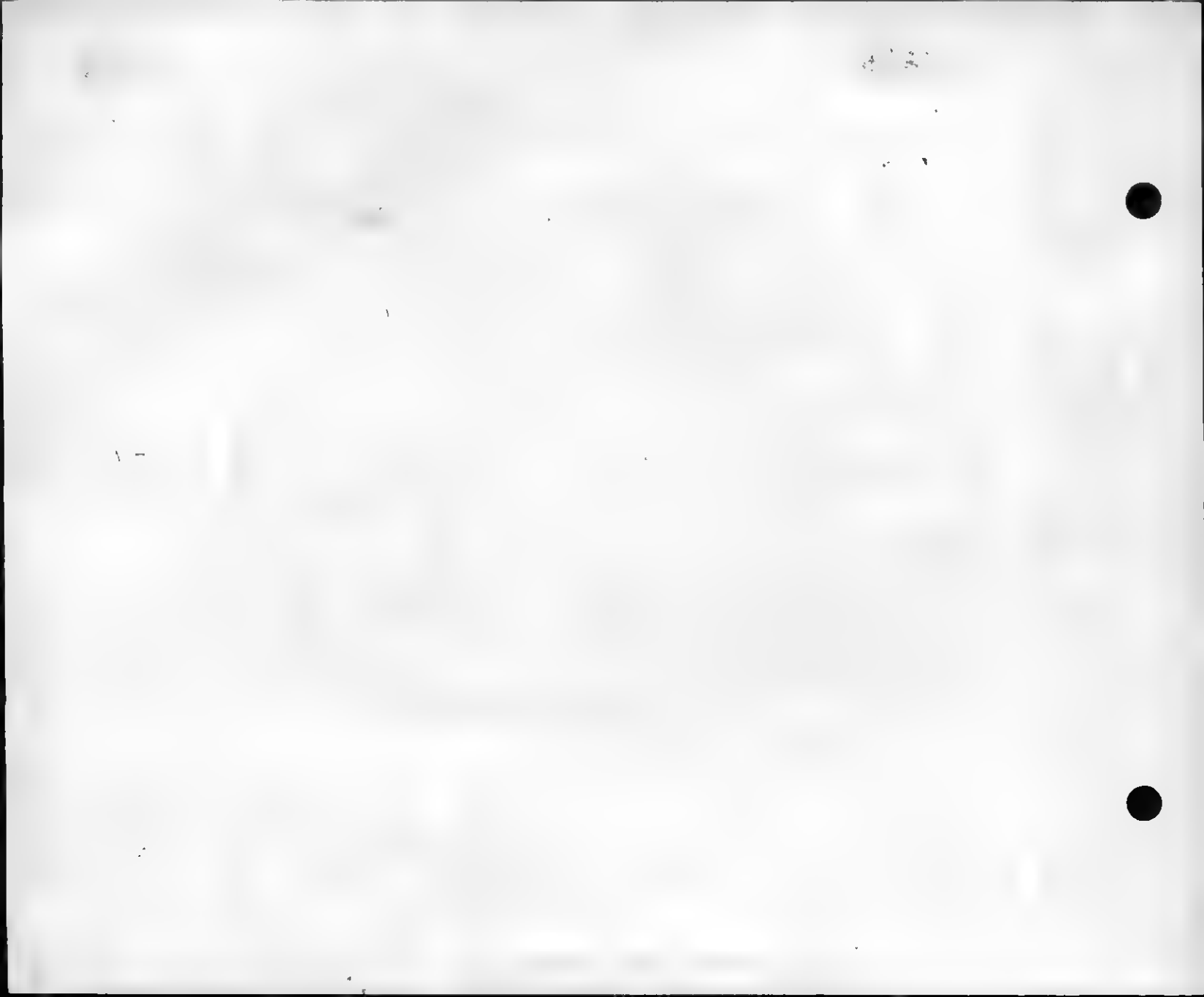
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01753

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Manor Convalescent Home</u>				d. STREET ADDRESS <u>6421 Cedonia Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry E.</u> Middle <u>Bruckey</u> Last <u></u>				4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 29, 1876</u>	9. AGE (in years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Bruckey</u>				14. MOTHER'S MAIDEN NAME <u>Susan -</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u>705-12-3905</u>		17. INFORMANT <u>John E. Lilly - 28 Beech Drive - 21220</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1961 to 9 Feb 1967</u> , that (I) (we) last saw the deceased alive on <u>9 Feb 1967</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William Goodman</u>				22b. DATE SIGNED <u>10 Feb 67</u>		22c. PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN, M.D.</u>	
22d. ADDRESS <u>1532 Tulphur Lane Rd - 21227</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>John C. Miller Inc - 6415 Belair Road - 21206</u>				25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove-carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

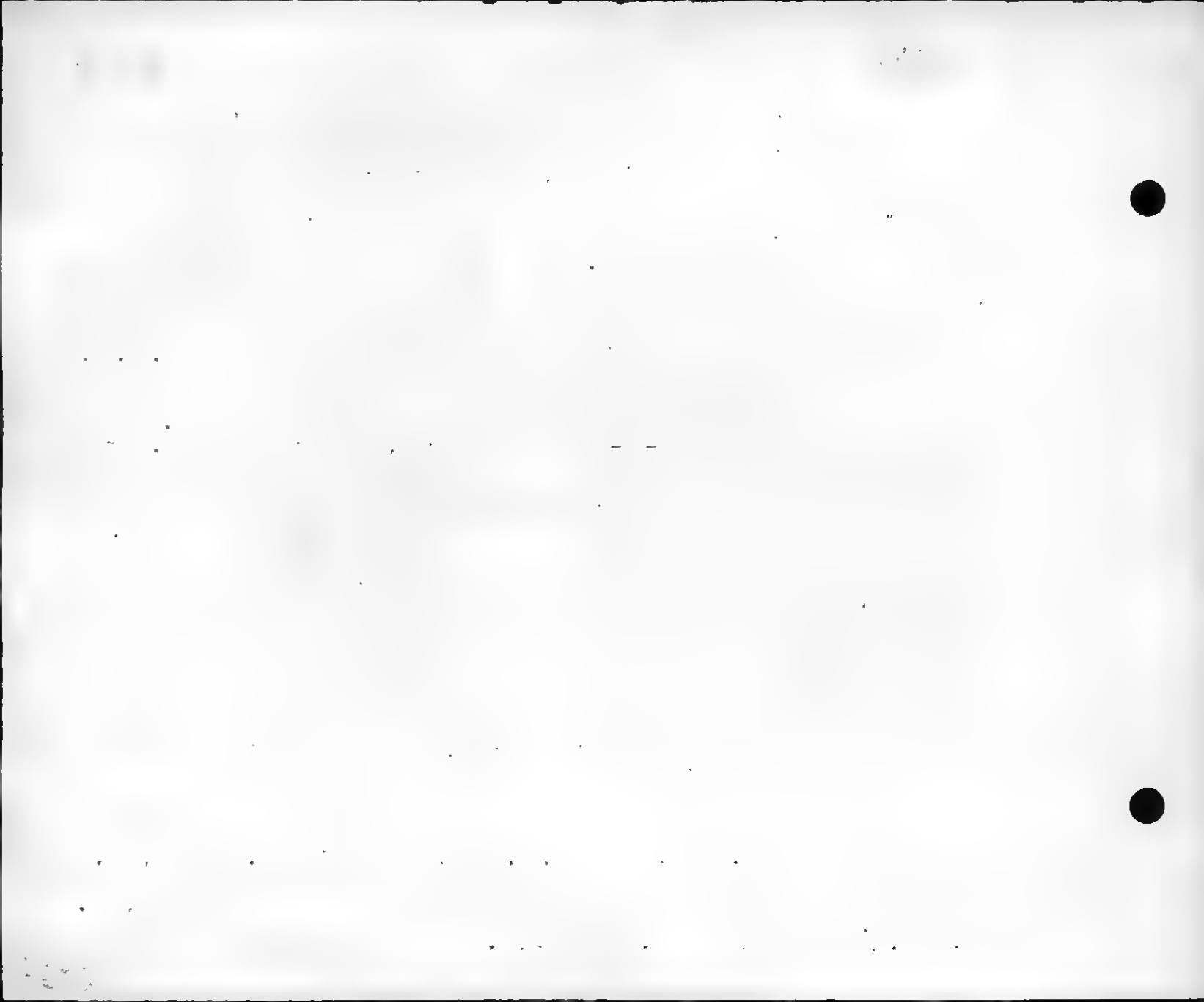
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01757

CERTIFICATE OF DEATH

01754

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN ID One Week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 307 Bayside Drive				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 307 Bayside Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eva Middle E. Last Bryant			4. DATE OF DEATH Month February Day 25 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 2/2/90		9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KING OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maine			
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Crocker					
14. MOTHER'S MAIEN NAME Not Known		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)					
16. SOCIAL SECURITY NO. 220-24-2212		17. INFORMANT June Stipek, 8341 Bear Creek Dr. Dundalk, Md. 21222					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema DUE TO (b) Influenza - Cardiac Failure DUE TO (c) Arterio-Sclerosis - Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH 1 day 1 week 5 years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from June , 1966, to 2/24 , 1967 that (I) (we) last saw the deceased alive on 2/24 1967, and that death occurred at A. M. from the causes and on the date stated above.					
22a. SIGNATURE Morris A. Jacobs		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/27/67			
22c. PHYSICIAN'S NAME (Type) Morris A. Jacobs		22d. ADDRESS M. D. 1010 North Point Rd. Dundalk, Md. 21224					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/28/67		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			
23d. LOCATION (City, town or county) (State) Baltimore, Md.		24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.					
25a. REC'D BY REGISTRAR FEB 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					



1. **FOR STATE HEALTH DEPT.**

TO DEPUTY AL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
SM 9/60

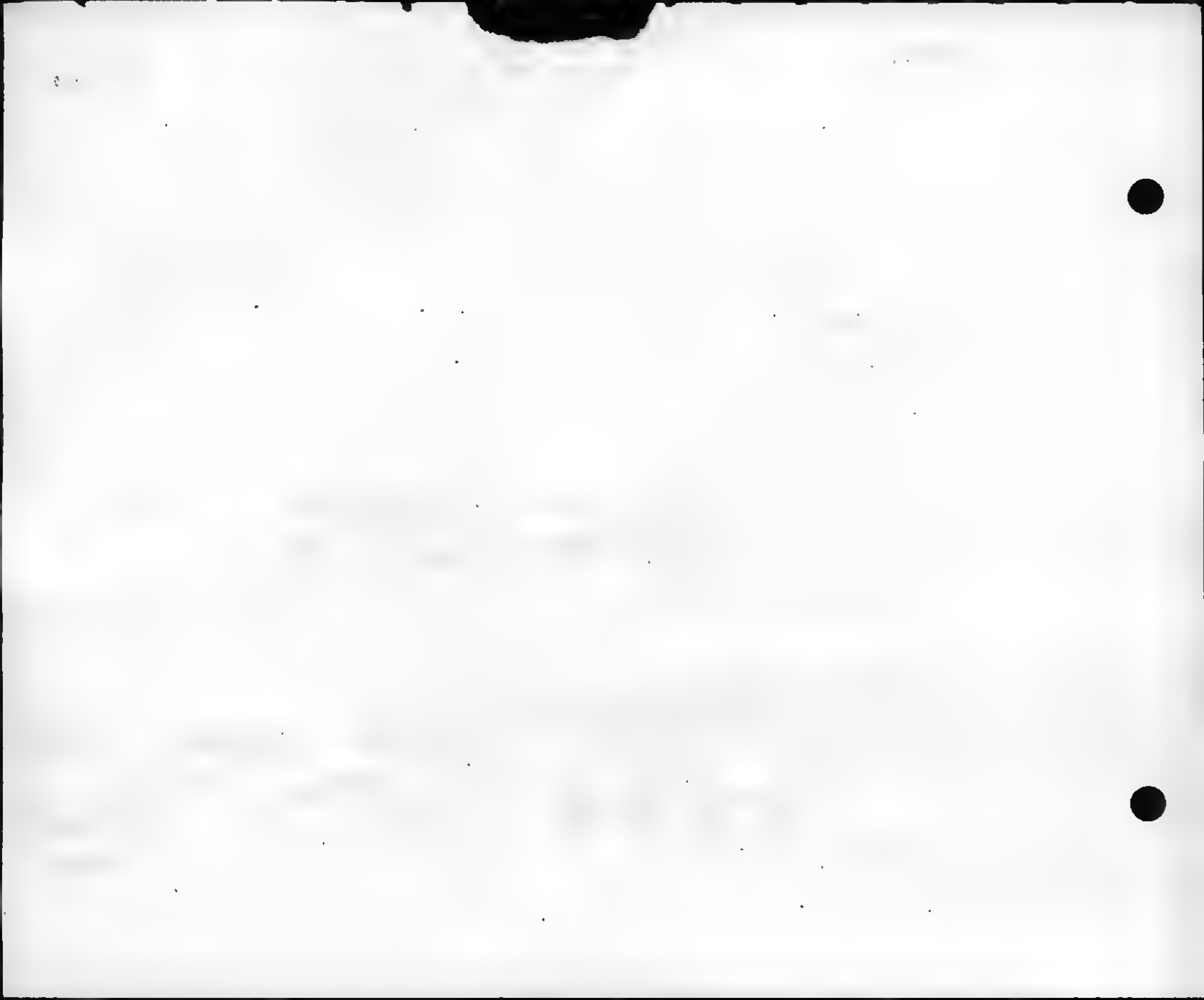
<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemore c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7207 Bucher Road				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemore d. STREET ADDRESS 7207 Bucher Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ANN BUCHER 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Dec. 22, 1901 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR: Months 9 Days 9 IF UNDER 24 HRS.: Hours 19 Min. 67				4. DATE OF DEATH February 9, 1967 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME Peter Bestry 14. MOTHER'S MAIDEN NAME Maryanna 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT Martin R. Bestry 5703 Belle Vista Ave. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V- Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) No 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) DATE SIGNED M.B. Davis MD - 6800 Mount Vernon - Baltimore 2/15/67 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-11-1967 22c. NAME OF CEMETERY OR CREMATORY Holy Rosary 22d. LOCATION (City, town, or country) Baltimore County, Maryland 23. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave. 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE B 10 1967							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>01759</p> </div> <div> <p>01756</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cotonsville</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				d. STREET ADDRESS <u>1314 Birch Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Paradise Nursing Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Anna E.</u> Middle <u>Burns</u> Last <u></u>						4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 14, 1881</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John H. Schwarzkopf</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Catherine Radenhi</u> Address <u>1314 Birch Ave</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>① Cerebral thrombosis</u> <u>202X</u> DUE TO (b) <u>② Chronic Brain Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>associated with Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>5 yrs</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u></u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>4/9/65</u>		20f. (City or town) (County) (State) <u>2/15/67</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>4/9/65</u> to <u>2/15/67</u> , that (I) (we) last saw the deceased alive on <u>2/13/1967</u> , and that death occurred at <u>12 Noon</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>W.E. McInath</u>						22b. DATE SIGNED <u>2/17/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>W.E. McInath</u>						22d. ADDRESS <u>1363 Frederick Ave. Cotonsville, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>			
24. FUNERAL DIRECTOR <u>Amber Inc 1328 Sulphur Spring Rd.</u>						25a. REC'D BY REGISTRAR <u>1-2-20-1301</u>		25b. REGISTRAR'S SIGNATURE <u></u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

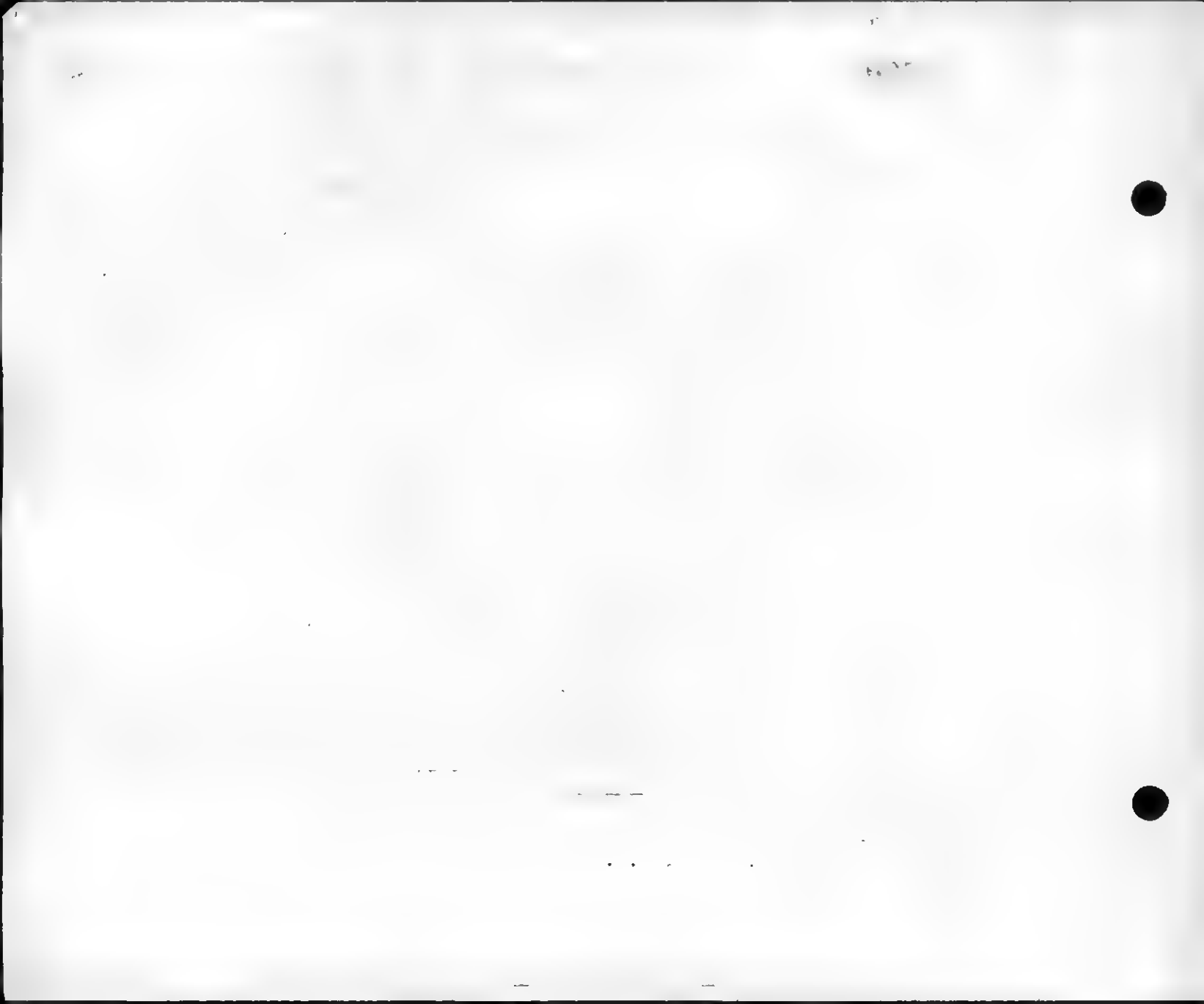
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01760

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01757

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Newell Funeral Home				d. STREET ADDRESS 9309 Liberty Road			
3 NAME OF DECEASED (Type or print) First Orville Middle Clayton Last BURNSIDE				4 DATE OF DEATH Month February Day 22 , Year 19 67			
5 SEX Male		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Aug 7, 1931	
9 AGE (in years last birthday) 35 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHUCKER		10b. KIND OF BUSINESS OR INDUSTRY TRUCKING		11 BIRTHPLACE (State or foreign country) W VIRGINIA	
12. FATHER'S NAME THOMAS BURNSIDE				14 MOTHER'S MAIDEN NAME CORDIN --			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1950-1954				16 SOCIAL SECURITY NO 248-26-5843		17 INFORMANT Mrs Dorcas C CHARNEY 102 N CHARLTON	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Exposure to cold associated with acute alcoholism 9325 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) alcoholism							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fatty metamorphosis of liver							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Exposed to cold			
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) side of road	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.				22. DATE SIGNED February 23, 1967			
EXAMINER'S NAME (Type)				Address (Street, city, town, or county)			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 1, 1967		23c. NAME OF CEMETERY OR CREMATORY BALD NAT. Cem		23d. LOCATION (City or Town) (County) (State) Baltimore, Md	
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy				25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

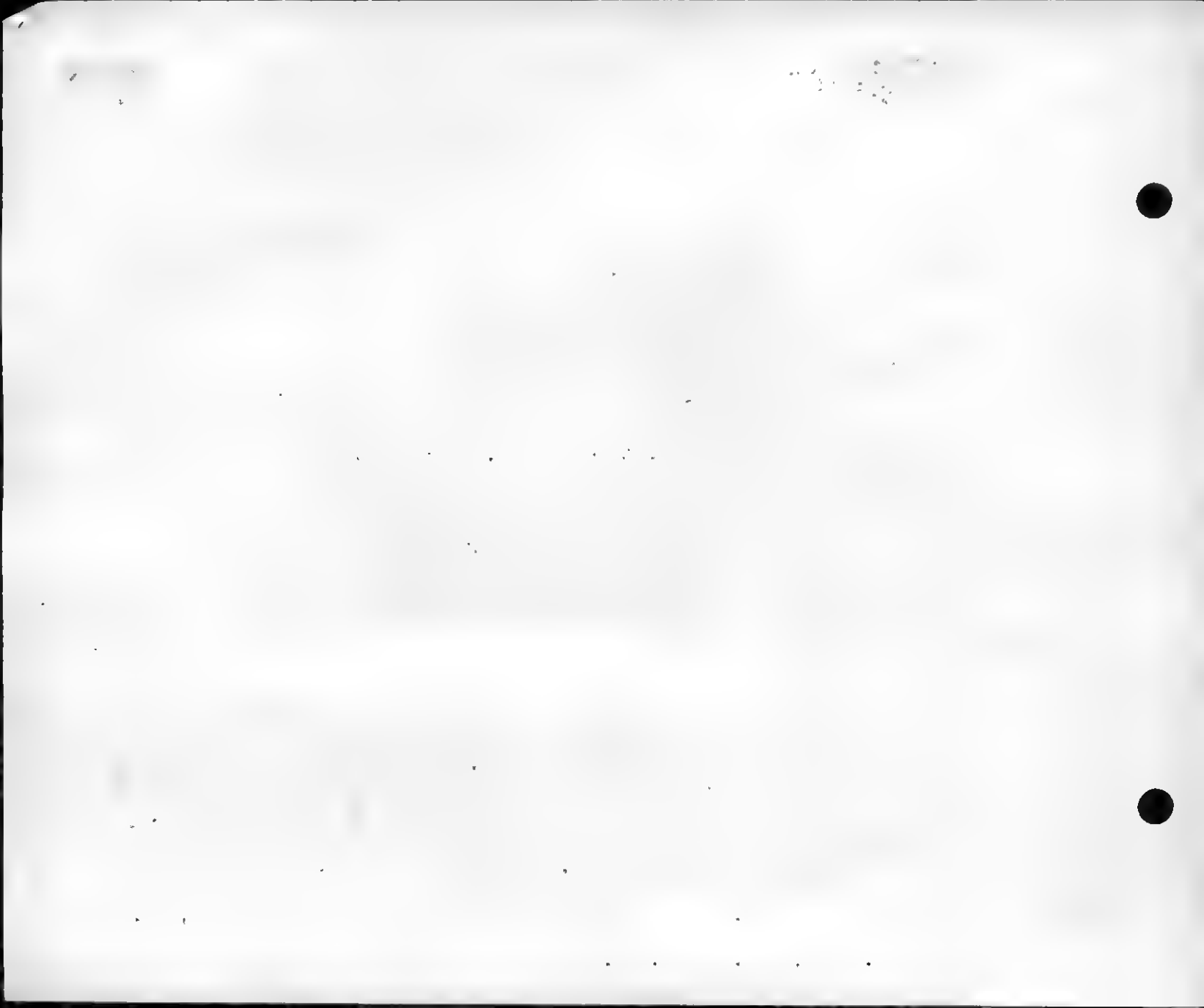
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01761

CERTIFICATE OF DEATH

01758

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY 	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY IN 1b Baltimore 21234	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d STREET ADDRESS 3025 Chesley Avenue	
3. NAME OF DECEASED (Type or print) First Euly Middle H. Last Burtch		4. DATE OF DEATH Month February Day 1 Year 19 67	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-92
9. AGE (In years last birthday) 74 yrs		10. FUND 1 YEAR Months Days Hours Min. 	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY Western Electric	
11 BIRTHPLACE (County & State, or foreign country) Kansas		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elwood Butch		14. MOTHER'S MAIDEN NAME Christina Paulstring	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 215-03-9572A	
17 INFORMANT Mrs. Grace Burtch		Address (Same)	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) possible strangulated hernia DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f (City or town) (County) (State)
21 I certify that 10 (this hospital) attended the deceased from Jan. 30 , 1967, to Feb. 1 , 1967, that 10 (we) last saw the deceased alive on Feb. 1 , 1967, and that death occurred at 12:30 AM , from causes and on the date stated above.			
22a SIGNATURE Lawrence F. Misanik, M.D.		22b DATE SIGNED Feb. 1, 1967	
22c PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d ADDRESS 7620 York Rd., Towson, Md. 21204	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 2/4/67.	23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a REC'D BY REGISTRAR 1967	
25b REGISTRAR'S SIGNATURE 		25c REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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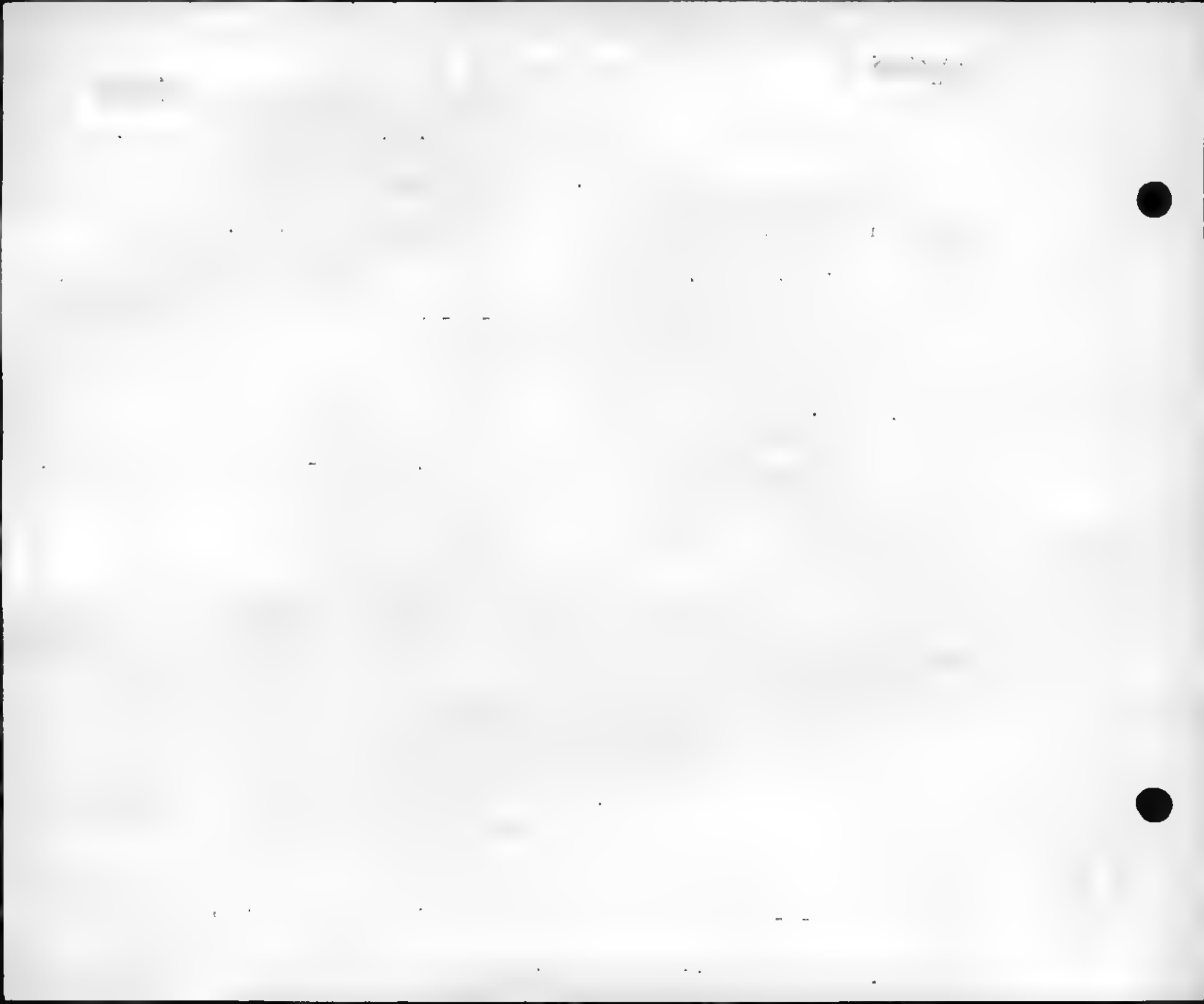
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01762

CERTIFICATE OF DEATH

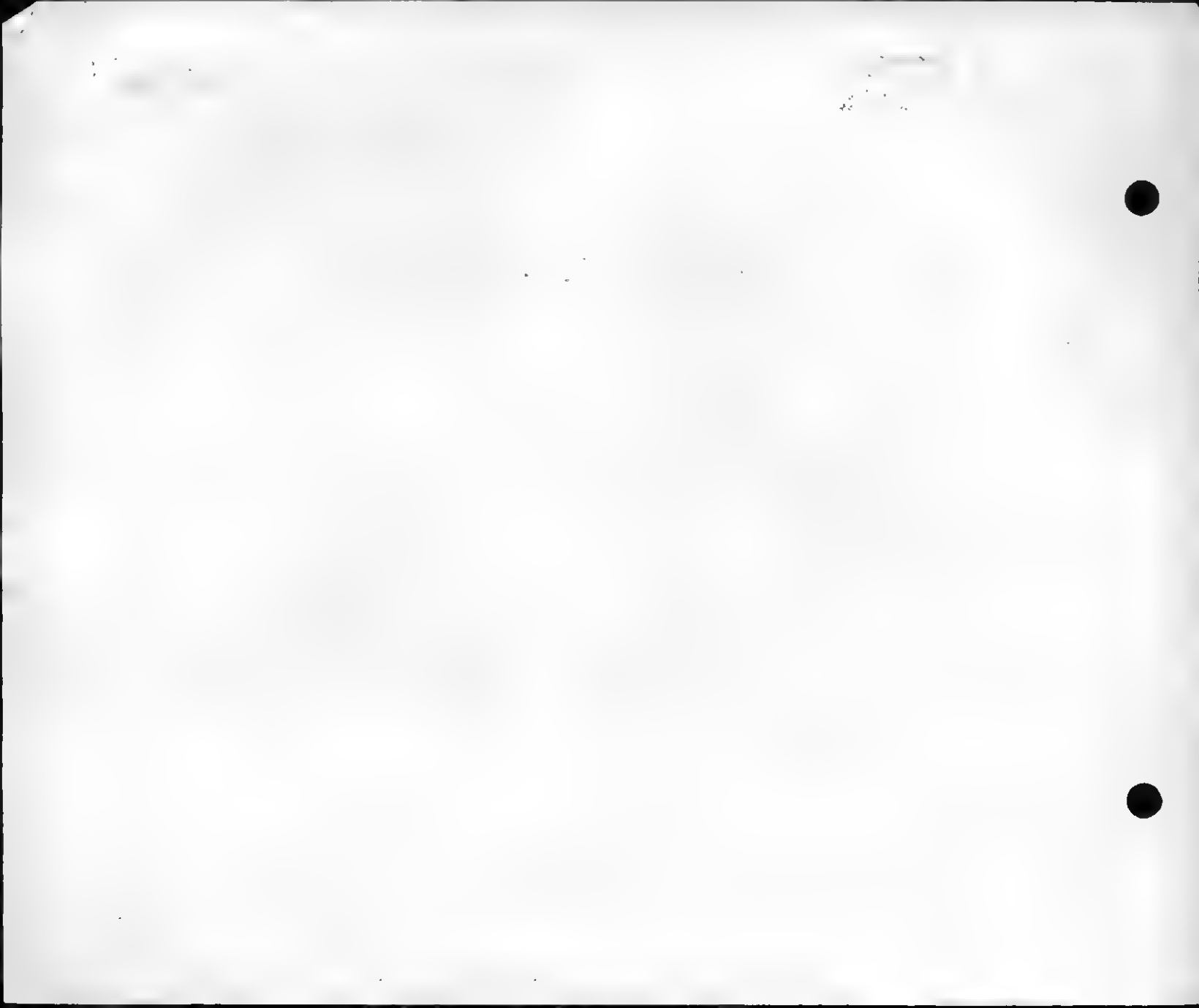
01759

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 17 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 6606 Windsor Mill Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6606 Windsor Mill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Evelyn L. Burton		4 DATE OF DEATH February 1 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 9-26-1896
9 AGE (in years last birthday) 70 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Baltimore		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Benjamin Franklin Lang		14. MOTHER'S MAIDEN NAME Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17 INFORMANT Evelyn M. Burton -6606 Windsor Mill Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Arteriosclerosis - generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Diabetes Mellitus (c) Strokes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Philip Bernstein M.D.		22b. DATE SIGNED 12/2/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-4-1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Edward Anderson		25a. REC'D BY REGISTRAR 6	
25b. REGISTRAR'S SIGNATURE 6		25c. DATE 1967	
25d. ADDRESS 4600 Liberty Hghts. Avenue		25e. REGISTRAR'S SIGNATURE 6	



TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

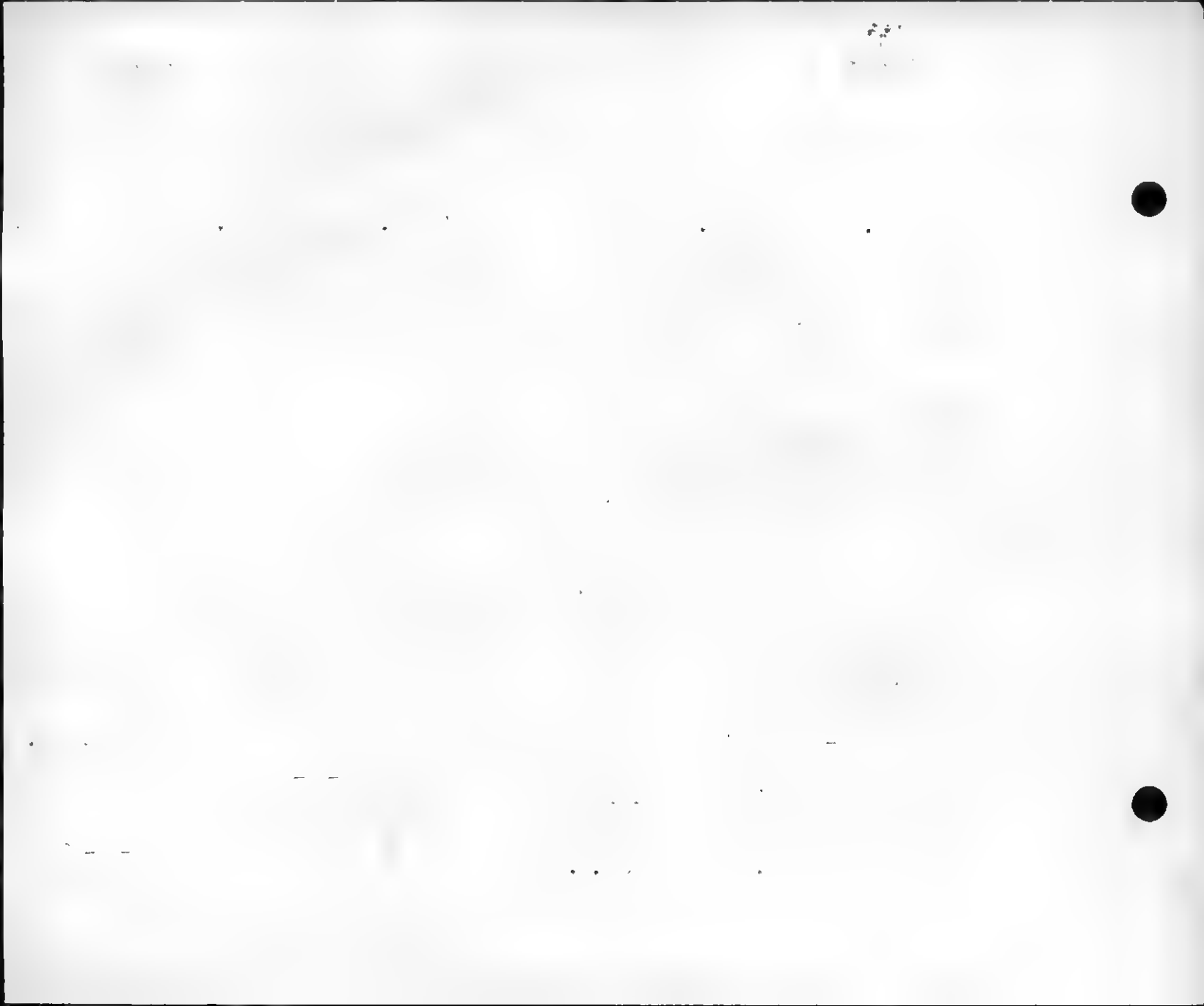
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01764

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01761

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7727 E. Baltimore St.		d. STREET ADDRESS 7713 E. Baltimore St.	
3 NAME OF DECEASED (Type or print) First JOSEPH Middle Last CAREY		4 DATE OF DEATH Pronounced February 25 Day Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/10/64
9 AGE (In years last birthday) 2 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) MD		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME ROBT C. CAREY SR.		14. MOTHER'S MAIDEN NAME MILDRED BALT2 CAREY	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO —	
17 INFORMANT R.C. CAREY		Address 7727 E BALTE ST	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Carbon monoxide DUE TO (c) Conflagration			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fire in row house	
20c. TIME OF INJURY Month, Day, Year 11:40 p.m. 2-24 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Baltimore (County) Md.			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/28/67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL	23d. LOCATION (City or Town) (County) (State) BALTO. MD.
24 FUNERAL DIRECTOR J. G. CONNELLY SON		25a. REC'D BY REGISTRAR MAR 1 1967	
ADDRESS 300 MACE		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

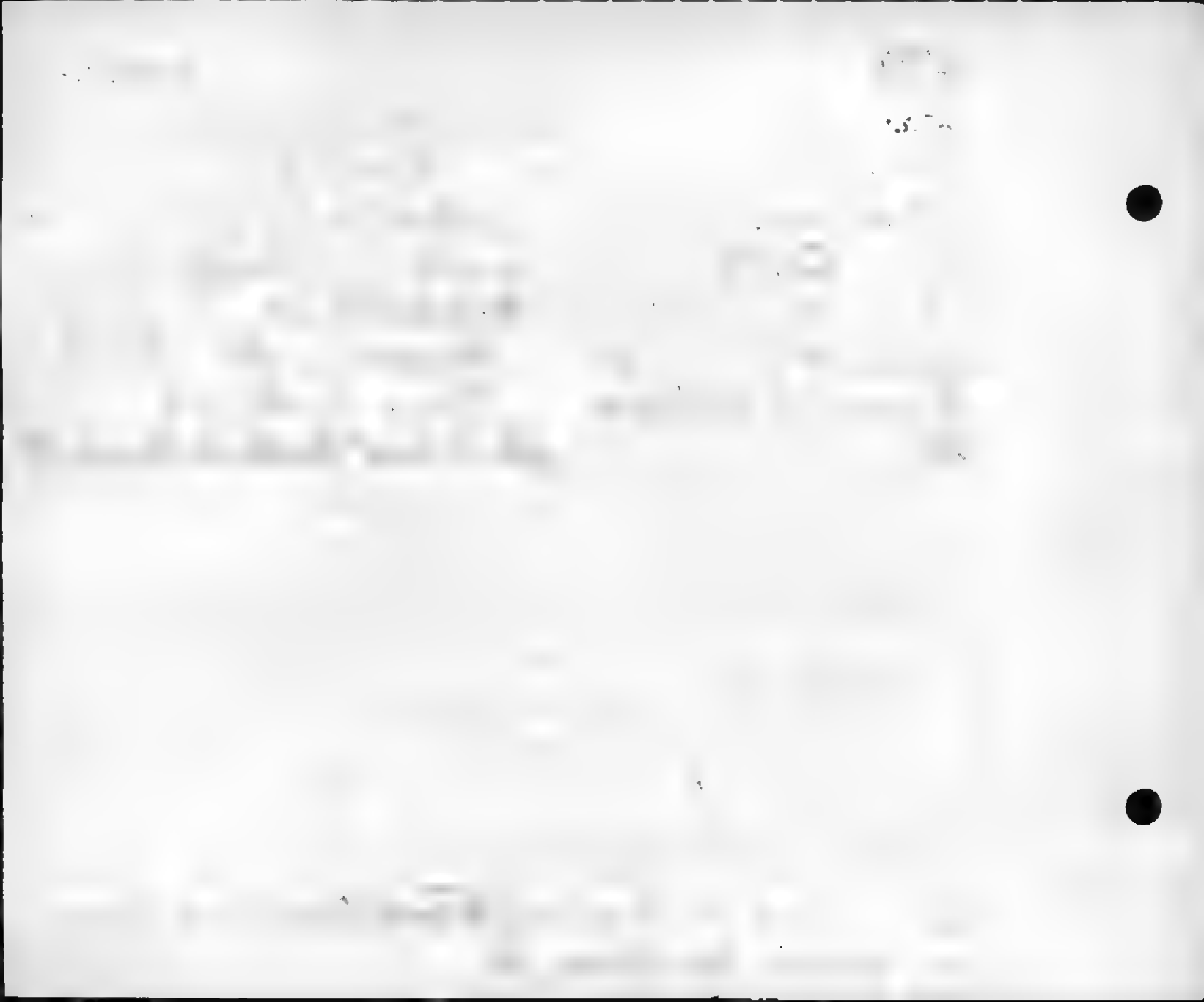
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01765

CERTIFICATE OF DEATH

01762

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> c. LENGTH OF STAY IN lb <u>24 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monkton Rd</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> d. STREET ADDRESS <u>Monkton Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>W.</u> Last <u>Carroll</u>				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 22, 1884</u> 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniel S. Wilhelm</u>				14. MOTHER'S MAIDEN NAME <u>Tacie B. Morris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>John A. Carroll, Monkton Rd, Monkton, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterio sclerosis C.V. Disease</u> DUE TO (c) <u>Hypertension C.V. Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> , 19 <u>60</u> , to <u>2-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-14</u> , 19 <u>67</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert Mueller Jr</u>				22b. DATE SIGNED <u>2-15-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. HERBERT MUELLER JR</u>				22d. ADDRESS <u>PARKTON MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Febr. 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fawn Grove Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Fawn Grove Penna.</u>	
24. FUNERAL DIRECTOR <u>Jacob Hartenstein, New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR <u>FEB 15 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. J. J.</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

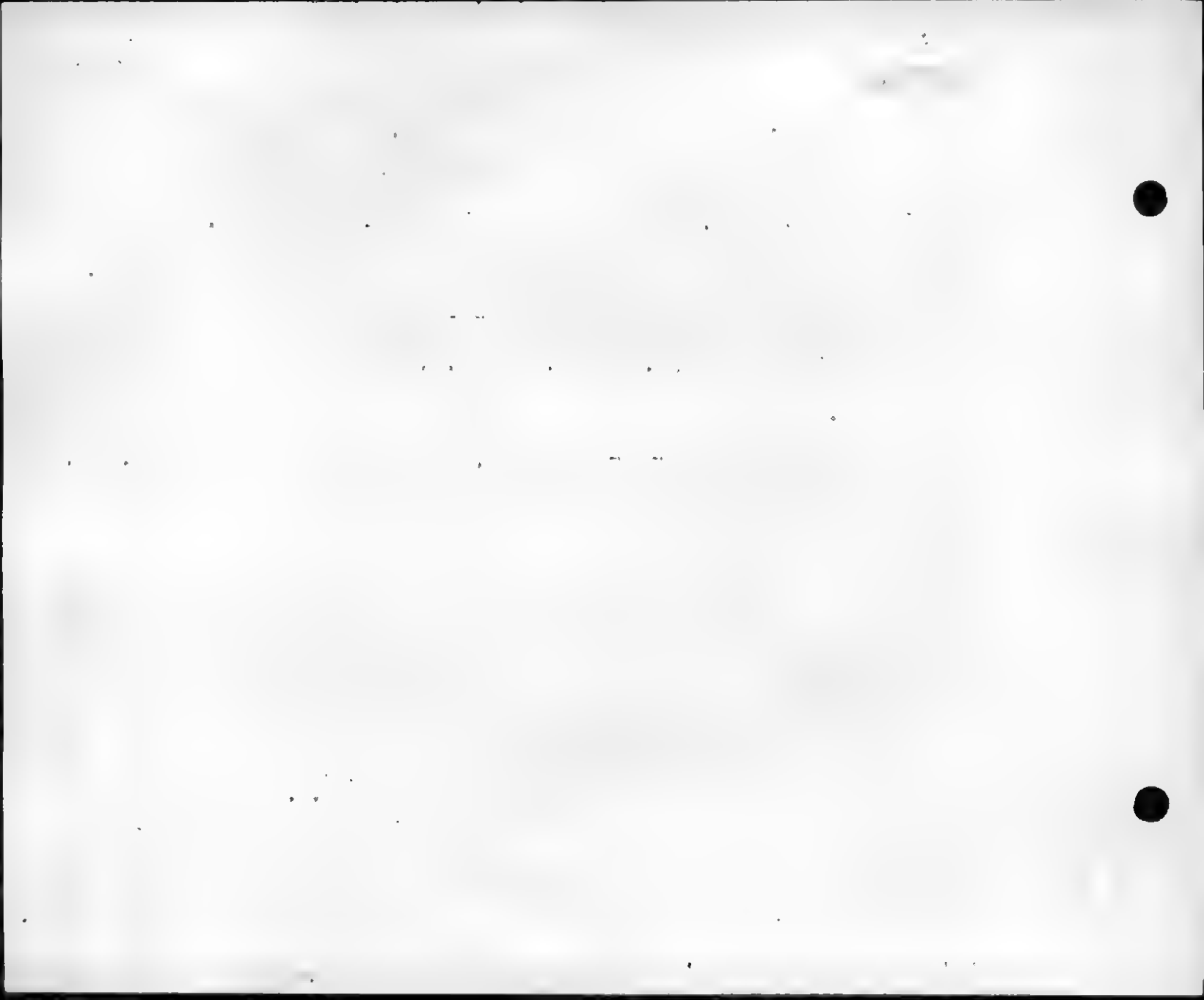
CERTIFICATE OF DEATH

01766

01763

1. PLACE OF DEATH a. COUNTY Baltimore, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			c. LENGTH OF STAY IN TOWN _____			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor N.H.				d. STREET ADDRESS 3914 Cloverhill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John H. Latrobe First Middle Last				4. DATE OF DEATH February 2nd, 1967 Month Day Year			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-9-1881	
9. AGE (in years last birthday) 85 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy Inspector		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (County & State, or foreign country) N.J.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Andrew K. Cogswell			
14. MOTHER'S MAIDEN NAME Virginia Latrobe				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 180-24-5800A		17. INFORMANT Mrs. John Heyrman		Address Balto., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASHD DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 , to Feb 2 1967 , that (I) (we) last saw the deceased alive on Feb 2 1967 , and that death occurred at 3:05 P.M. from causes and on the date stated above.							
22a. SIGNATURE F.M. DUGAN				22b. DATE SIGNED 2/3/67		22c. PHYSICIAN'S NAME (Type) F.M. DUGAN	
22d. ADDRESS 15 E. Belle St Baltimore 21202				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-4-67		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd., Balto				25a. REC'D BY REGISTRAR DATE -- 3 1967		25b. REGISTRAR'S SIGNATURE _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

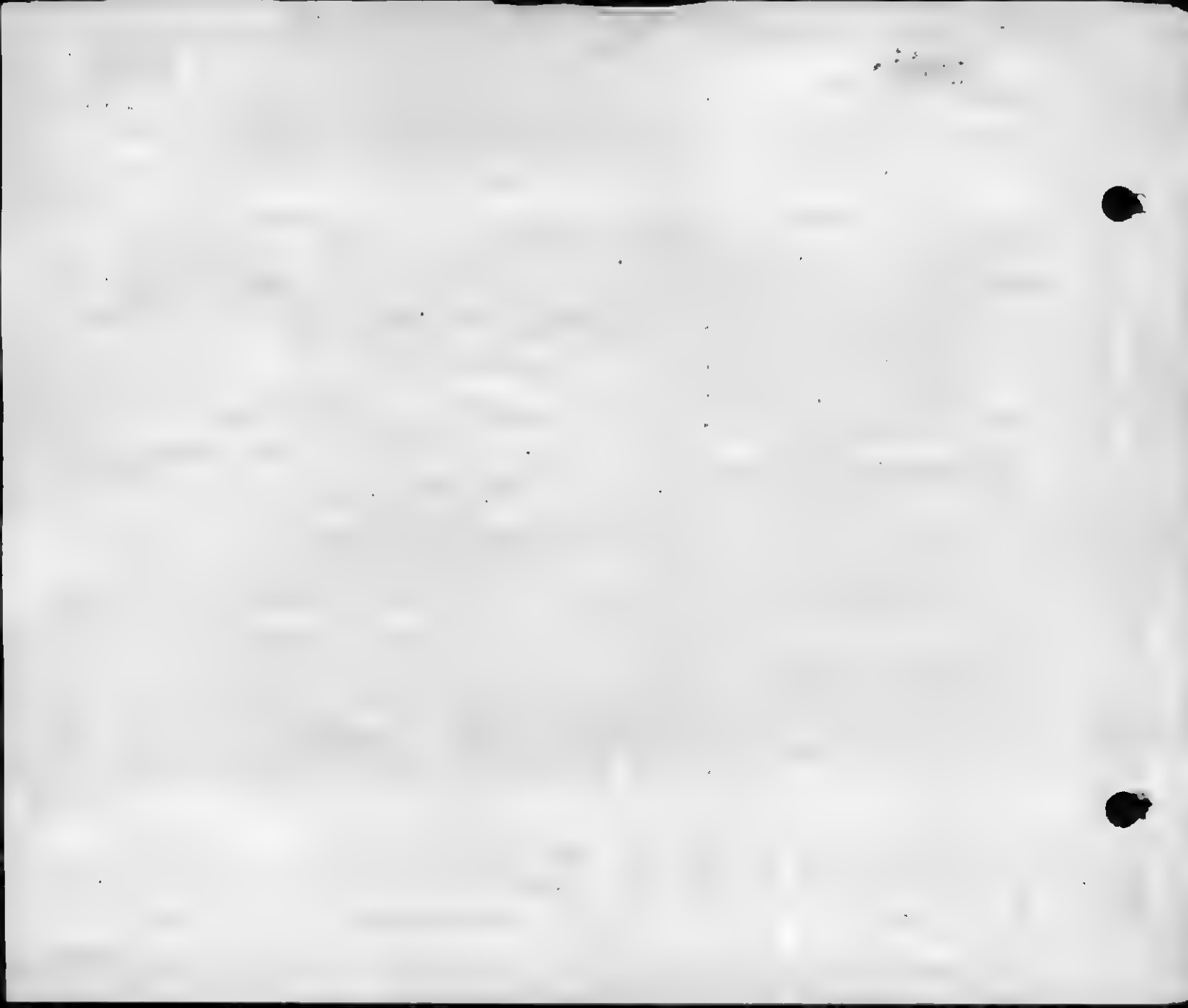
CERTIFICATE OF DEATH

01767

01764

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN Tb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1415 Woodcliff Avenue 28				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 1415 Woodcliff Avenue 28 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Julia A. Coleman		4. DATE OF DEATH February 8, 1967		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 5, 1889		9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months 1 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Isaac E. Gardner				14. MOTHER'S MAIDEN NAME India Hook			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Herbert Pinkston		Address same address as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Atherosclerotic Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 1960 to FEB 8, 1967 , that (I) (we) last saw the deceased alive on FEB 8, 1967 , and that death occurred at 11 M, from the causes and on the date stated above							
22a. SIGNATURE Thomas E. Wheeler MD				22b. DATE SIGNED 2/9/67		22c. ADDRESS Randall Station - Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tubner & Sons				25a. REC'D BY REGISTRAR DATE FEB 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 1 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



01768

CERTIFICATE OF DEATH

01765

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst-tut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN 1b <u>Baltimore #34</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7710 Queen Anne Drive</u>		d. STREET ADDRESS <u>Queen Anne Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>A.</u> Last <u>Connolly</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 8, 1887</u>
9. AGE (In years, month, day) <u>79</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of work ing life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Rittershofer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hoenniker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-01-4467</u>	
17. INFORMANT <u>Mr. Albert J. Connolly</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dissecting</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2 February, 1967</u> , to <u>3 February, 1967</u> , that (I) (we) saw the deceased alive on <u>3 February, 1967</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John W. Brenaby</u>		22b. DATE SIGNED <u>4 Feb 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN W. BRENBABY</u>		22d. ADDRESS <u>1531 E. North Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/7/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01769.

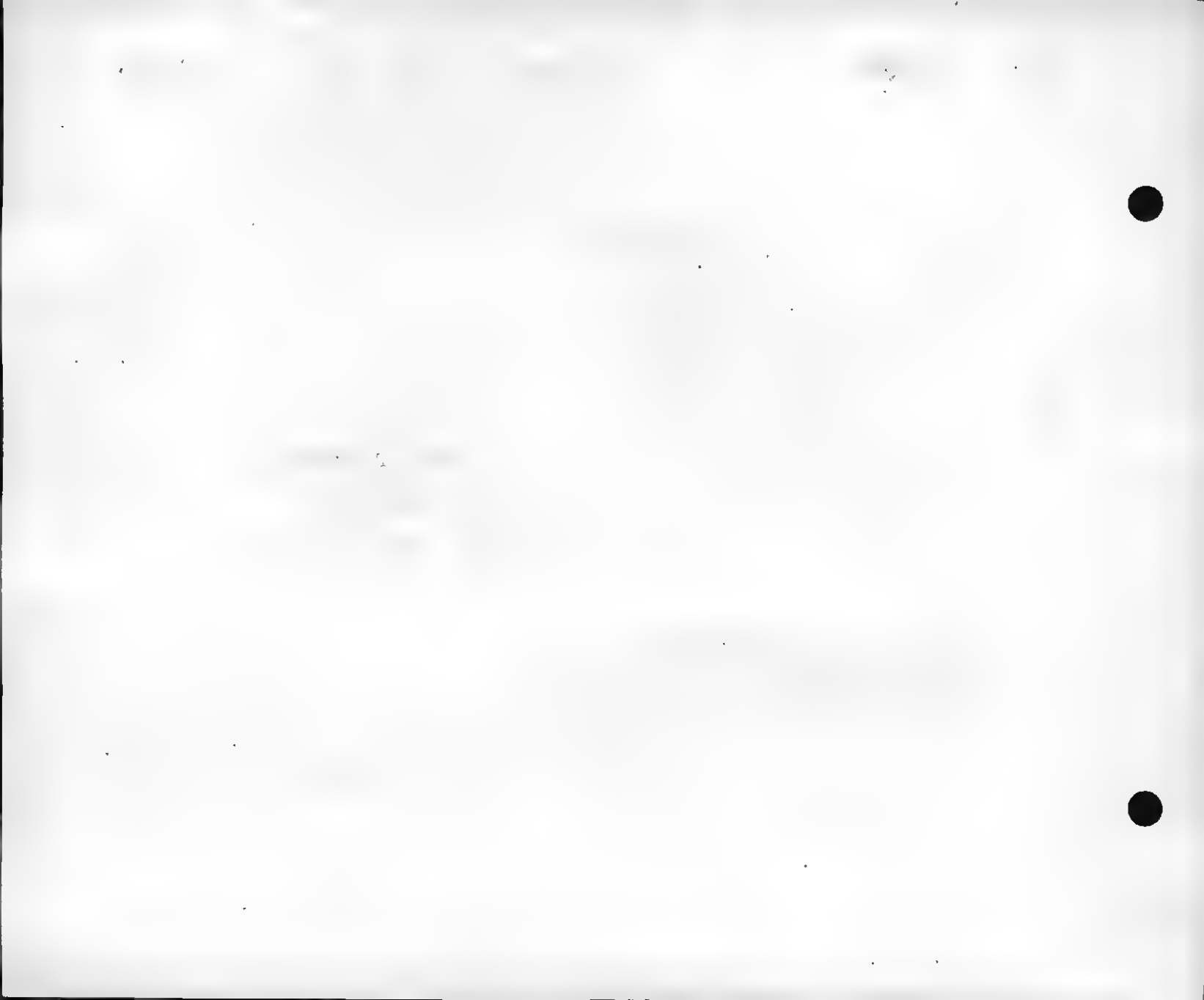
CERTIFICATE OF DEATH

01766

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus d. STREET ADDRESS 4750 Westland Blvd. e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HENRIETTA R. CONNOR First Middle Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 13. FATHER'S NAME Otto Schroen 14. MOTHER'S MAIDEN NAME Catherine M. Crou				4. DATE OF DEATH February 1, 19 67 Month Day Year 8. DATE OF BIRTH 4-13-1903 9. AGE (In years last birthday) 63 yrs IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Hours Min 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. Marie F. Walters, 1001 DeSota Road				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 15 min. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from Oct 21, 1948 to Feb 1, 1967 , that (I) (we) last saw the deceased alive on Jan 31 1967 , and that death occurred at 9:30 M, from causes and on the date stated above.					
22a. SIGNATURE Dr. A. Bradley Daugharthy M.D. 22c. PHYSICIAN'S NAME (Type) Dr. A. Bradley Daugharthy				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d. ADDRESS 1264 Francis Avenue				22b. DATE SIGNED Feb 2, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-4-1967		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229				25a. REC'D BY REGISTRAR DATE FEB 3 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
01770					01767				
1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRISON MD</u> c. LENGTH OF STAY IN 1b <u>3 YRS 3 MO</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FOXLEIGH NURSING HOME</u>					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>Ambassador Apartments</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>MARTHA</u>			First Middle Last <u>CONNOR</u>		4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1967</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 29 1882</u>		9. AGE (in years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist-Designer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rev. James Conner</u>					14. MOTHER'S MAIDEN NAME <u>Jane Hallowell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Janet Stover, 11 Northampton Rd. Timonium</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO (b) <u>Left sided myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Coronary atherosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>✓</u> 19 p.m. <u>✓</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1-15-19</u> to <u>2-17-67</u> , that (I) (we) last saw the deceased alive on <u>2-17-19</u> and that death occurred at <u>11</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					22b. DATE SIGNED <u>2-18-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>					22d. ADDRESS <u>[Signature]</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Feb. 21, 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Barratts Chapel</u>		23d. LOCATION (City, town or county) (State) <u>Frederica, Del.</u>		
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md. 21204</u>					25a. REC'D BY REGISTRAR <u>FEB 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23c Film #332 37 2/57 ps

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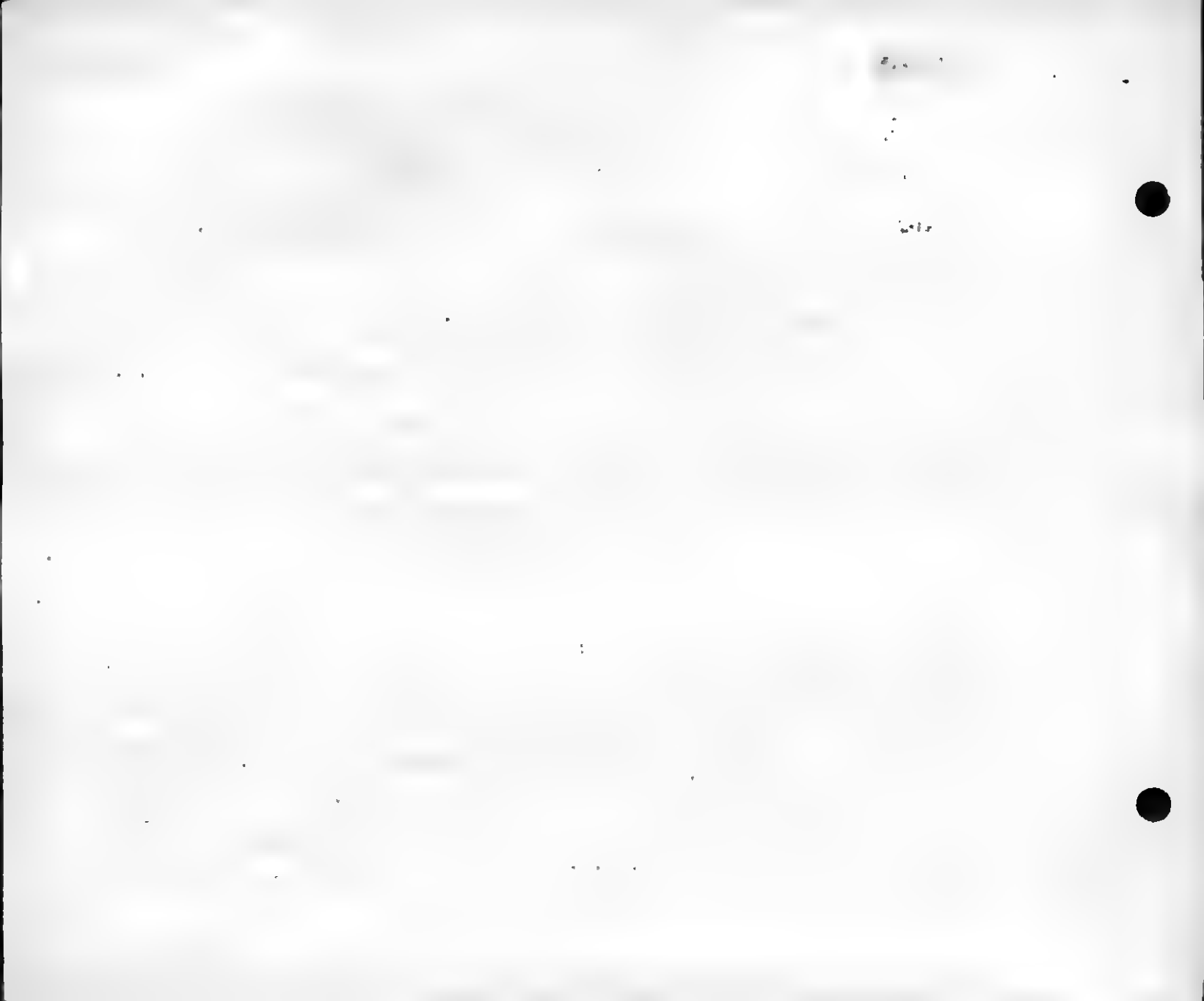
CERTIFICATE OF DEATH

01768

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN (b) 4mth28dys		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 325 North Carey St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Kenneth Middle Cook Last Cook		4 DATE OF DEATH Month February Day 11 Year 1967	
5 SEX male	6 COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1916
9. AGE (in years last birthday) 50 yrs		IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11 BIRTHPLACE (County & State, or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Issah Cook		14. MOTHER'S MAIDEN NAME Maggie Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16 SOCIAL SECURITY NO unknown	
17 INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma, old DUE TO 531X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral hemorrhage DUE TO 5 mths. (c) Arteriosclerotic cerebral vascular disease 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 5 mths	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized: Arteriosclerotic cardiovascular		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) heart disease	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that the (this hospital) attended the deceased from June 4, 1966 to Feb. 11, 1967 , that the (we) last saw the deceased alive on Feb. 11, 1967 , and that death occurred at 4:00 M, from causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 2-14-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Anatomy Board	23d. LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR		25a. RECD BY REGISTRAR DATE FEB 20 1967	25b. REGISTRAR'S SIGNATURE Worles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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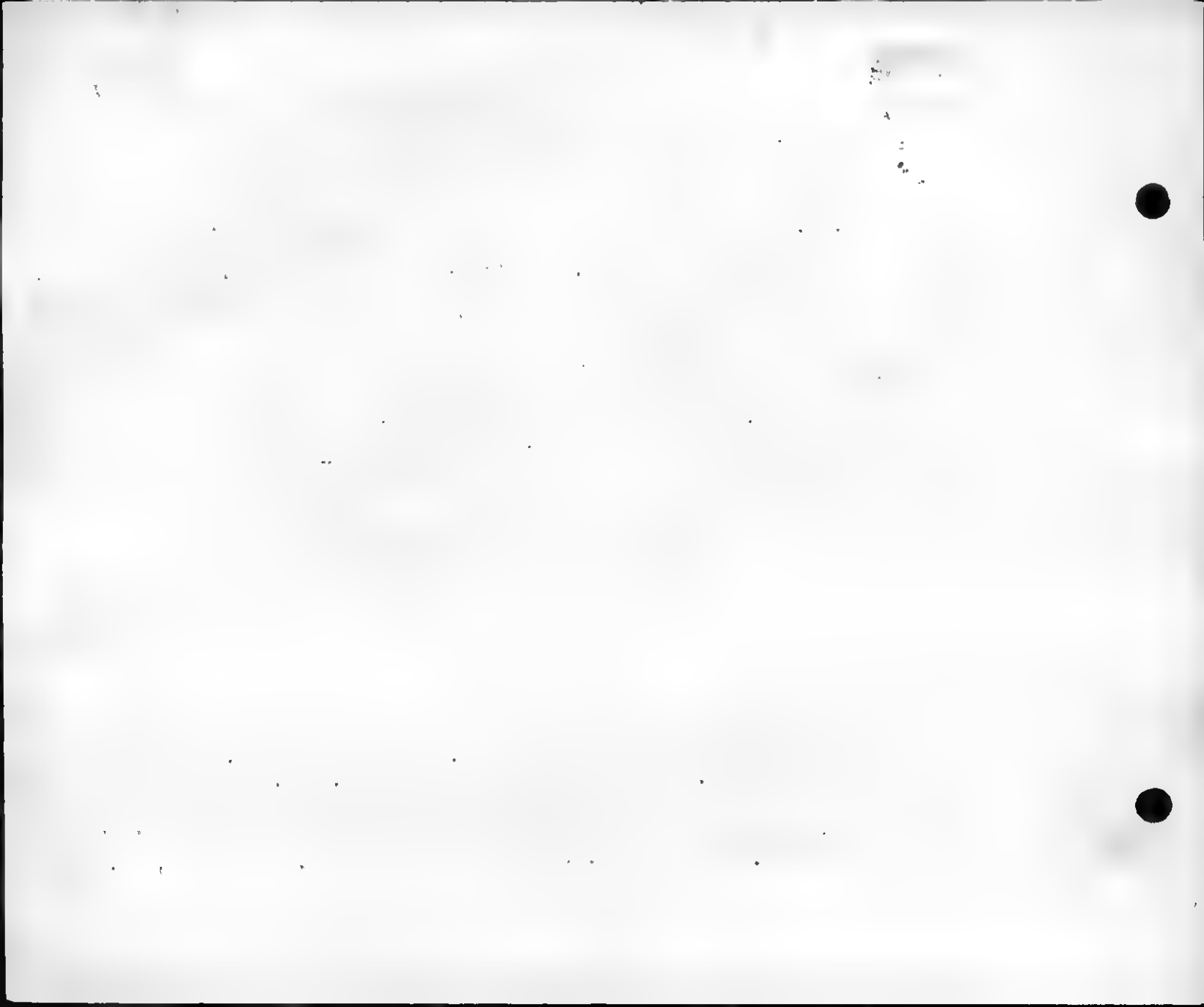
CERTIFICATE OF DEATH

01769

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 13-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Corder				4. DATE OF DEATH Month Feb. Day 24 Year 19 67			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/18/90	
9. AGE (In years last birthday) 76 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U-S-A		13. FATHER'S NAME GEORGE W. HANCOCK		14. MOTHER'S MAIDEN NAME ISABELLE SCHRADER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. etc.) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary E. Seinkuhler		Address Balto. Md.		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Pleural effusion (b) Pulmonary Cancer DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital heart failure due to arteriosclerotic cardio-vascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that the (this hospital) attended the deceased from Feb. 15 , 19 67 to Feb. 24 , 19 67 , that (I) (we) last saw the deceased alive on Feb. 24 , 19 67 , and that death occurred at 10:30 PM from causes and on the date stated above		22a. SIGNATURE Nelson S. de la Paz M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Feb. 24, 1967	
22c. PHYSICIAN'S NAME (Type) Nelson S. de la Paz, M.D.		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-28-67	
23c. NAME OF CEMETERY OR CREMATORY HANCOCK CEMETERY		23d. LOCATION (City or Town) (County) (State) LITTLE CREEK, VA.		24. FUNERAL DIRECTOR Charles Miller - 2334 Jefferson St.		25a. REC'D BY REGISTRAR MAR 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME		25d. REGISTRAR'S ADDRESS		25e. REGISTRAR'S PHONE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01773 CERTIFICATE OF DEATH 01770

1. PLACE OF DEATH a. COUNTY. <u>Baltimore</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN 15 <u>21215</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paradise Nursing Home</u>			d. STREET ADDRESS <u>4644 Pall Mall Road</u>		
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Cox</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1967</u>		
5. SEX <u>F.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>3/16/1877</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Upperco, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Thomas Alban</u>		
14. MOTHER'S MAIDEN NAME <u>Resh</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		
16. SOCIAL SECURITY NO. <u>213-36-3749</u>			17. INFORMANT <u>Mrs. James A. Reidler, Jr.</u> Address <u>3700 Campfield Rd</u> <u>21207</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio-Vascular</u> <u>4221</u> DUE TO <u>Dissect.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Large Drenphrenetic Hernia - 5 yrs.</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>1/4/62</u> to <u>2/9/67</u> , that (I) (we) last saw the deceased alive on <u>2/8/67</u> , and that death occurred at <u>800 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>W E Mc Grath</u>			22b. DATE SIGNED <u>2/9/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>W E Mc Grath MD</u>			22d. ADDRESS <u>1303 Frederick Rd</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salem E. U. B.</u>	
23d. LOCATION (City, town or county) <u>Baltimore, County, Md.</u>		23e. (State) <u> </u>			
24. FUNERAL DIRECTOR <u>Loring Byers</u>		24a. ADDRESS <u>-8728 Liberty Rd. Randallstown, Md</u>		24b. DATE <u>FEB 14 1967</u>	
25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>			

753



1-1-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

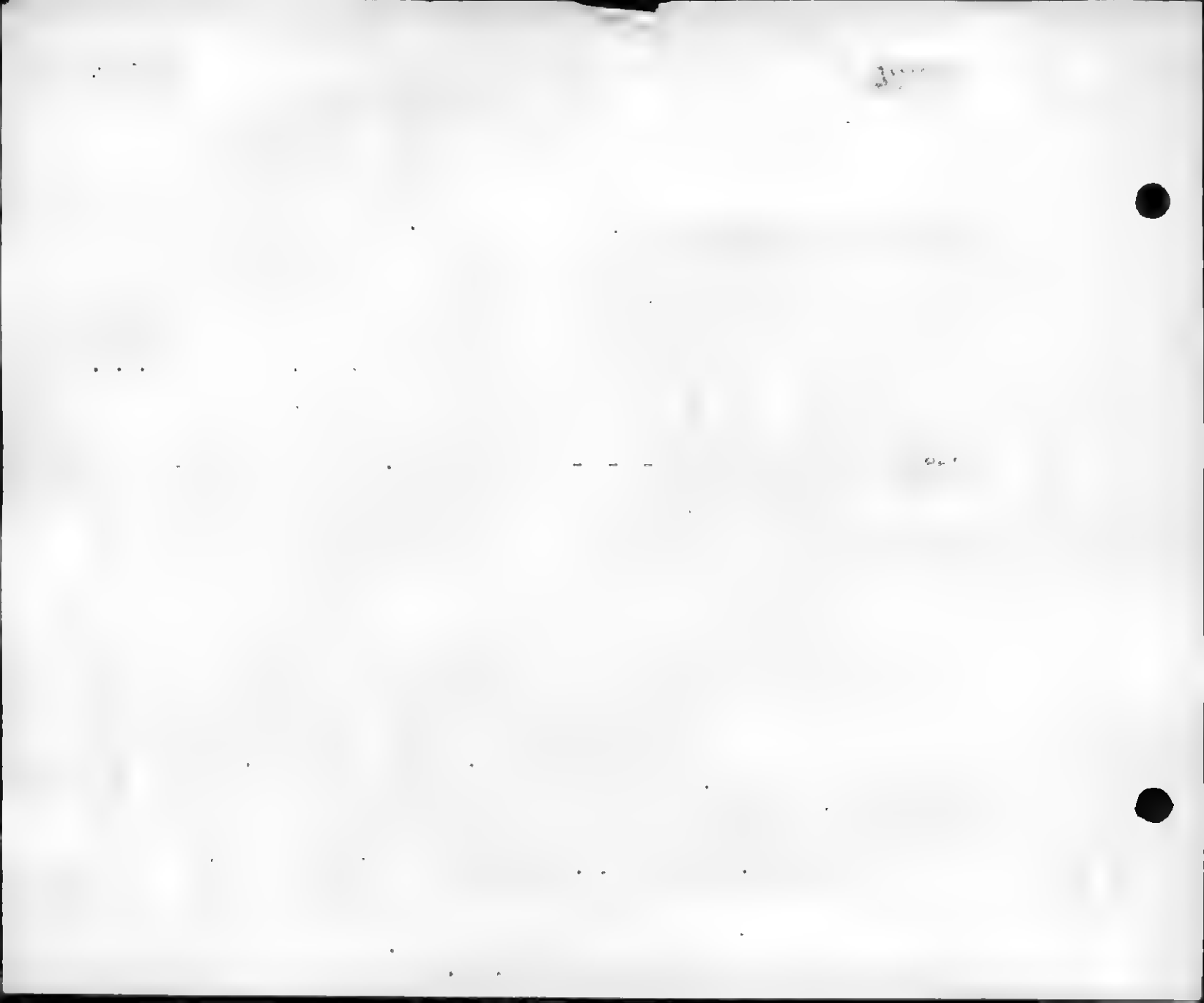
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01774

CERTIFICATE OF DEATH

01771

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 405 N. Duncan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First THOMAS Middle JOSEPH Last COX				4. DATE OF DEATH Month FEBRUARY Day 17 Year 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/27/13	9 AGE (In years last birthday) yrs 53	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>		IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Cox				14. MOTHER'S MAIDEN NAME Anna Drehoff			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO 216-05-47-34		17. INFORMANT Address Clinical Rec. VAH, Fort Howard, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMORRHAGE FROM DUODENAL ULCER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) POLYCYTHEMIA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Minutes Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 14 , 1967, to Feb. 17 , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 17 , 1967, and that death occurred at 5:00 PM from causes and on the date stated above.							
22a. SIGNATURE <i>Sheldon E. Kalmutz</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/18/67	
22c. PHYSICIAN'S NAME (Type) SHELDON E. KALMUTZ, M.D.				22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/67		23c. NAME OF CEMETERY OR CREMATORY Bahemian Nation		23d. LOCATION (City or town) (County) (State) Baltimore	
24. FUNERAL DIRECTOR <i>Phillip Herwig</i>				25a. REC'D BY REGISTRAR St.		25b. REGISTRAR'S SIGNATURE <i>Phillip Herwig</i>	
PHILLIP HERWIG & SONS FUNERAL HOME Balto, Md.				DATE FEB 20 1967			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01775

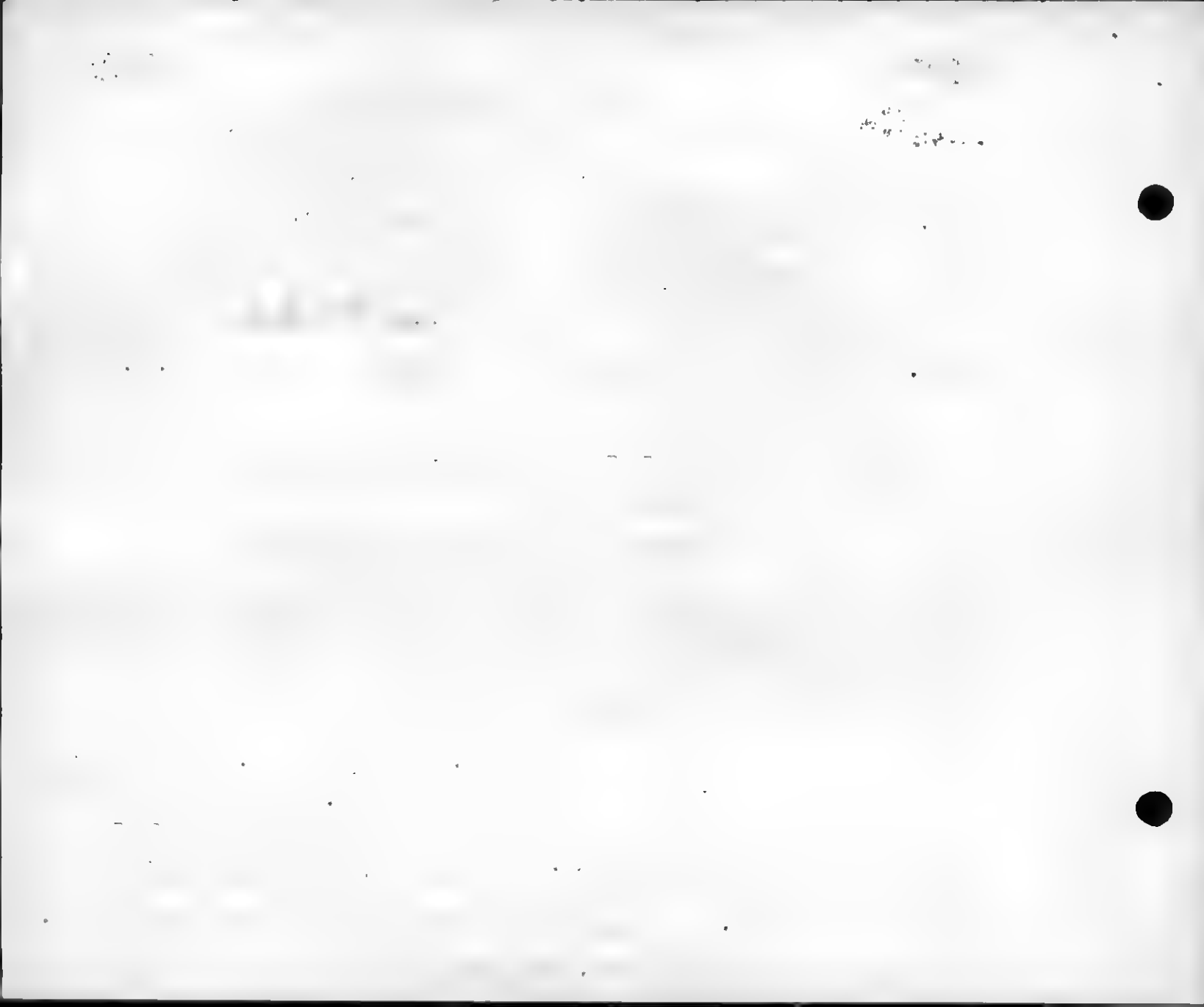
CERTIFICATE OF DEATH

01772

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4 mths 2 dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 649 West Bel Air Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George John Creswell				4. DATE OF DEATH Month Day Year February 20 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1893	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maint. Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Railroad (B&O)		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Creswell				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-09-7392		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition - Dehydration						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 8, 1960 to Feb. 20, 1967 that (we) last saw the deceased alive on Feb. 20, 1967 , and that death occurred at 9:00 M, from causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar				22b. DATE SIGNED 2-20-67		22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 23 Feb. 67		23c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		23d. LOCATION (City or Town) (County) (State) Aberdeen Harford Md.	
24. FUNERAL DIRECTOR Tarring Funeral Home				25a. REC'D BY REGISTRAR FEB 23 1967		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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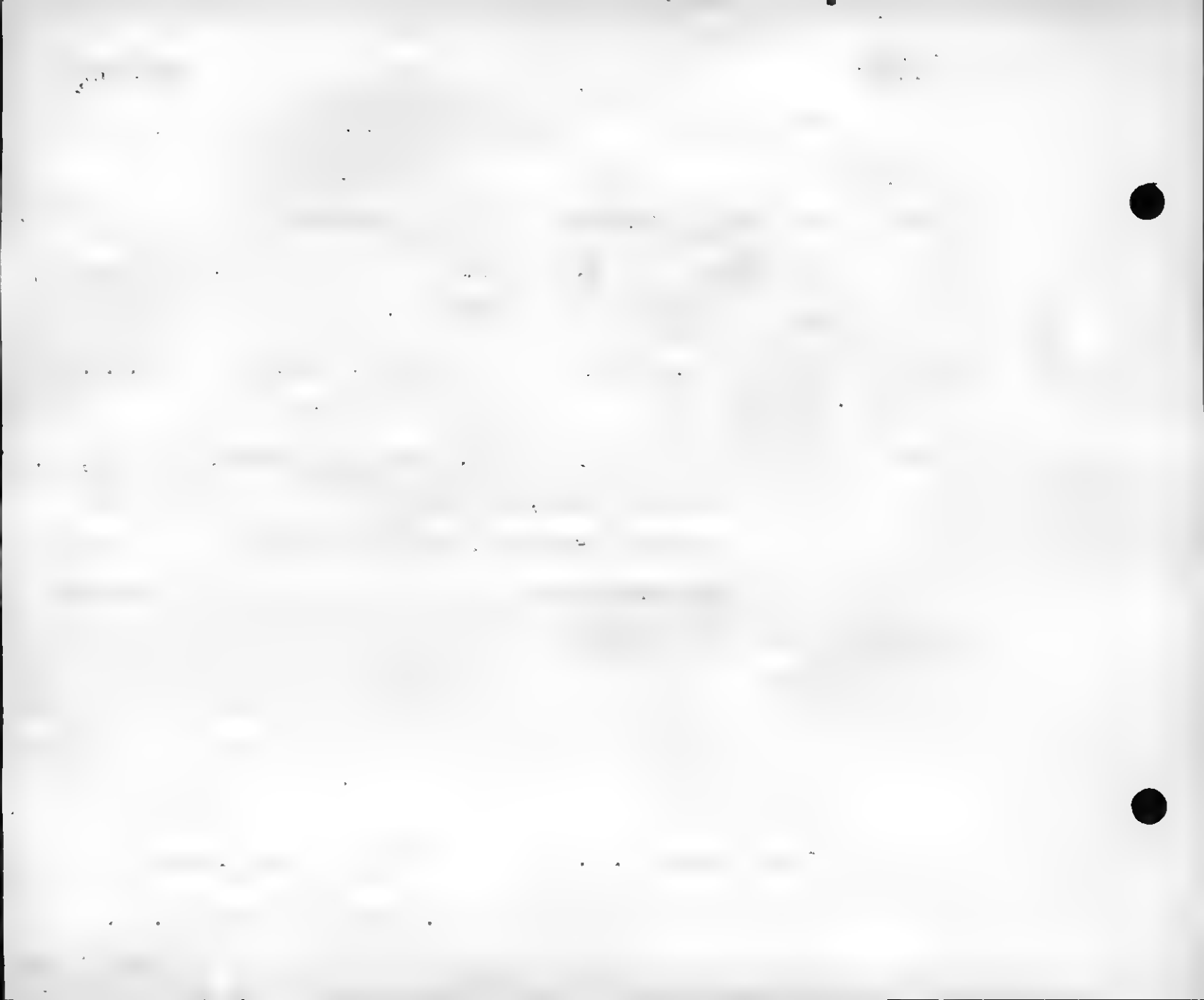
CERTIFICATE OF DEATH

01773

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RJRAL and give nearest town) FORT HOWARD		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside of corporate limits, write RJRAL and give nearest town) COCKEYSVILLE	
3 NAME OF DECEASED (Type or print) First GEORGE Middle B. Last CROFT		4 DATE OF DEATH Month FEBRUARY Day 12 Year 1967	
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 13, 1924
9 AGE (In years last birthday) 42		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC	
10b KIND OF BUSINESS OR INDUSTRY AUTOMOBILE		11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME GEORGE A. CROFT		14. MOTHER'S MAIDEN NAME DAISY MYERS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW II		16 SOCIAL SECURITY NO 214 22 45 79	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA, BILATERAL DUE TO (b) DIABETIC NEPHROPATHY, NEPHROTIC SYNDROME DUE TO (c) DIABETES MELLITUS		INTERVAL BETWEEN DEATH AND DEATH DAYS UNKNOWN UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 1/12/67 , 19____, to 2/23/67 , 19____, that (we) last saw the deceased alive on 2/23/67 , 19____, and that death occurred at 8:25AM from causes and on the date stated above.			
22a SIGNATURE <i>Neilson</i>		22b. DATE SIGNED 2/23/67	
22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 2-27-67	
23c NAME OF CEMETERY OR CREMATORY DULANEY VALLEY MEM. GARDENS BALTIMORE CO. MD.		23d LOCATION (City or town) (County) (State)	
24 FUNERAL DIRECTOR WM COOK BROOKS TOWSON		25a REC'D BY REGISTRAR TOWSON, MARYLAND	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c DATE FEB 28 1967	

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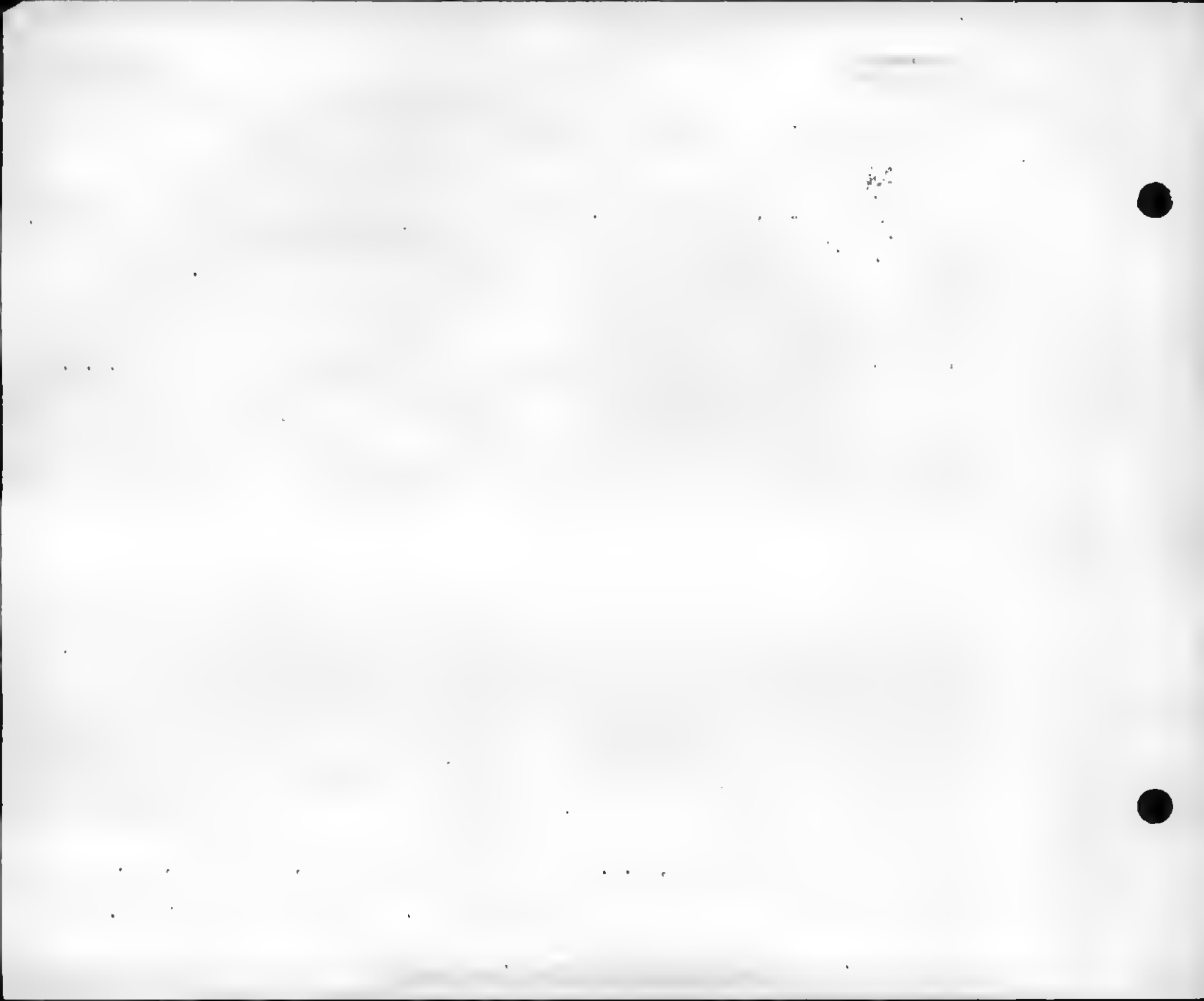
01777

CERTIFICATE OF DEATH

01774

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN Tb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, 7620 York Rd. 21204				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1278 Beaumont Avenue 21212 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last ROMEO (Ray) D'ADAMO		4. DATE OF DEATH Month Day Year Feb. 12 19 67		5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-7-13		9. AGE (In years last birthday) 53 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Inspector		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James D'Adamo						14. MOTHER'S MAIDEN NAME Gioconda Pezzella													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no						16. SOCIAL SECURITY NO 107-120313		17. INFORMANT Louise D'Adamo Address sare											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)														INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 1-19-67, 19__, to 2-12-67, 19__, that (I) (we) last saw the deceased alive on 2-12-67, 19__, and that death occurred at 4:00 p.m. from causes and on the date stated above.																			
22a. SIGNATURE Arturo A. Pidlaoan MD						22b. DATE SIGNED 2-12-67				22c. PHYSICIAN'S NAME (Type) Arturo Pidlaoan, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) buried				23b. DATE THEREOF 2-16-67		23c. NAME OF CEMETERY OR CREMATORY Riverhurst Cemetery				23d. LOCATION (City or Town) (County) (State) Indicott, New York									
24. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Ind.						25a. REC'D BY REGISTRAR DATE FEB 14 1967		25b. REGISTRAR'S SIGNATURE [Signature]											

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

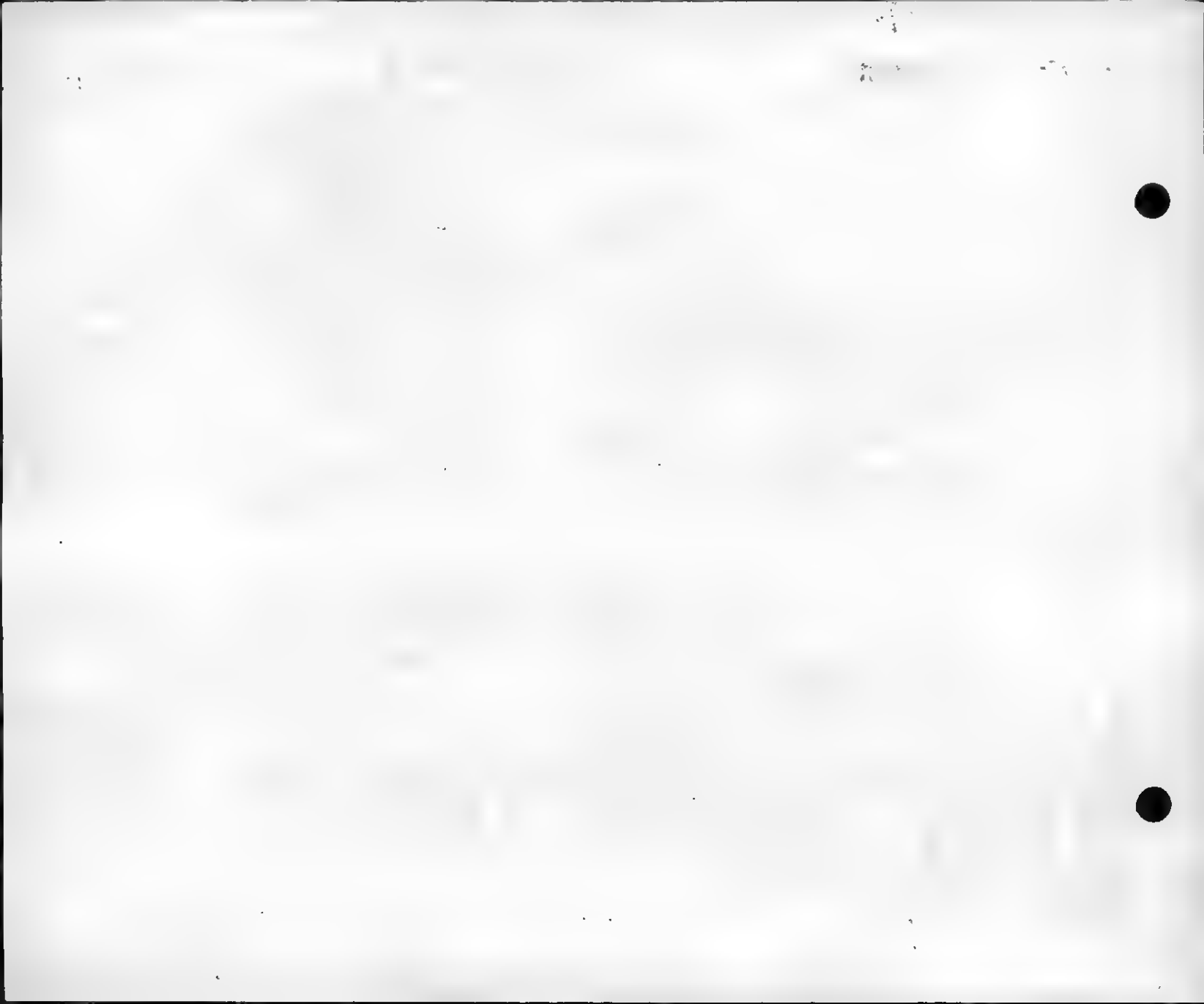
01778

CERTIFICATE OF DEATH

01775

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>5 mo. 9 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>VERNE ROAD STATE HOSPITAL</u>				d. STREET ADDRESS <u>110 W. BALTIMORE ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HELEN LOUISA DAUGHTON</u>				4. DATE OF DEATH Month Day Year <u>FEB. 21 1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-1891</u>	9. AGE (In years last birthday) <u>75</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cleaning (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANKS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ARTHUR</u>				14. MOTHER'S MAIDEN NAME <u>MARY GREENE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. INFORMANT <u>CHARLES DAUGHTON</u> Address <u>702 MAR... BALTIMORE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE C. A. V. MYO CARDIOMYOPATHY</u> DUE TO (b) <u>CARDIAC INSUFFICIENCY</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>34-45'</u> <u>27 YRS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 11, 1966</u> to <u>Feb. 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb. 18, 1967</u> , and that death occurred at <u>2:25 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Morris Meiller</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRIS MEILLER</u>				22d. ADDRESS <u>1130 BAKER AVE. BALTIMORE, MD. 21207</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>		23d. LOCATION (City or town) (County) (State) <u>WOODLAWN MD.</u>	
24. FUNERAL DIRECTOR <u>A. V. Singleton</u>				25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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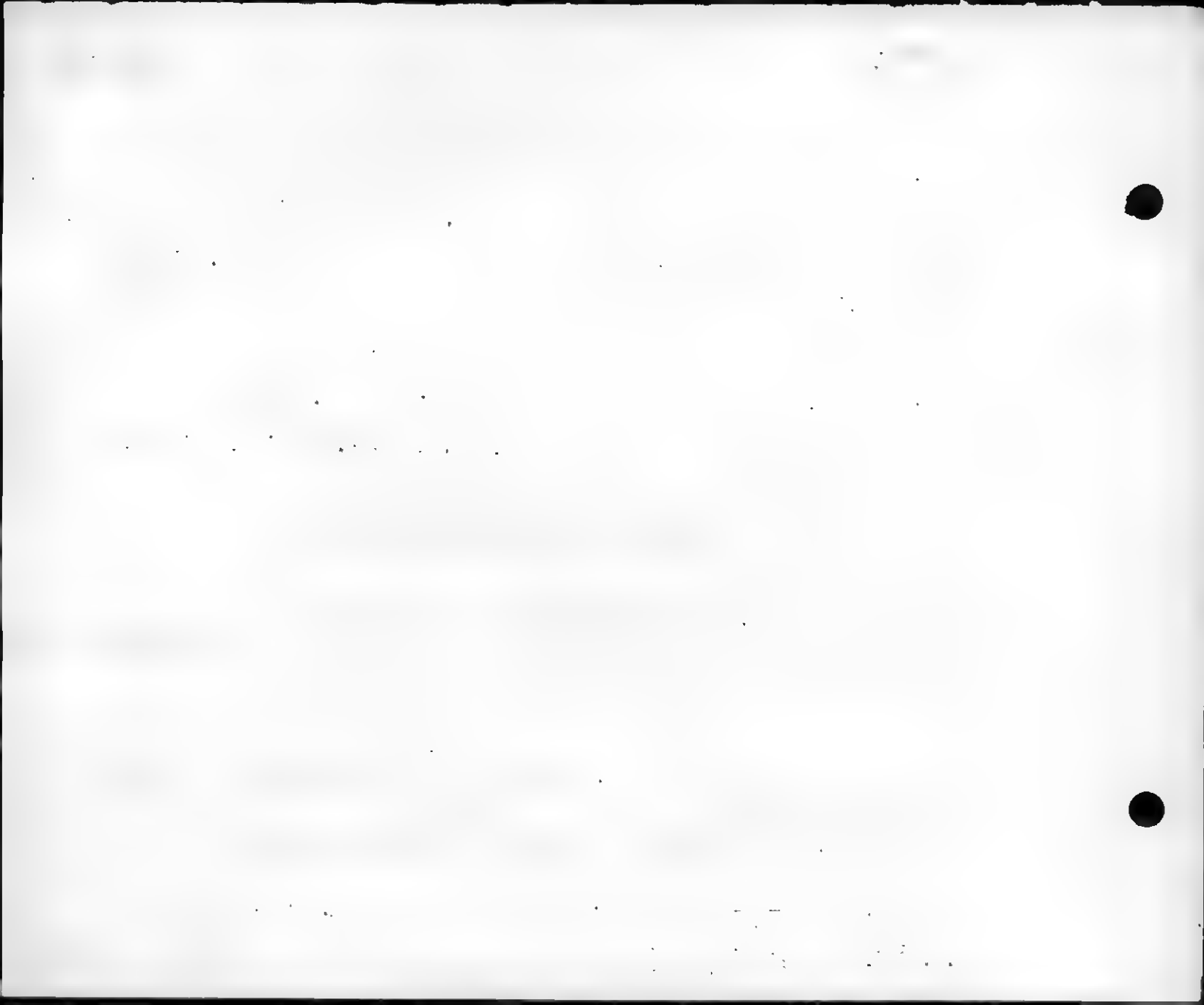
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01779

01776

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b Ellicott City,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House In The Pines				d. STREET ADDRESS Rt. 2 Box 51 A			
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS EVANS DAVIS				4. DATE OF DEATH Month Day Year Feb. 9, 1967 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1879	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Woodstock, Md		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME William Davis				14. MOTHER'S MAIDEN NAME Sallie E. Gorsuch			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary E. Davis, Rt. 2, Ellicott City, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 10 days 15 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-20-1967 , to 2-9-1967 , that (II) (we) last saw the deceased alive on 2-8-1967 , and that death occurred at 3:44 AM , from the causes and on the date stated above.							
22a. SIGNATURE Wilmer K. Gallagher Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-10-67	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, Jr.				22d. ADDRESS 4209 Frederick Ave. Balt. 28, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-11-1967		23c. NAME OF CEMETERY OR CREMATORY Holy Family		23d. LOCATION (City, town or county) (State) Harrissonville, Md	
24. FUNERAL DIRECTOR F.C. Higginbotham				25a. REC'D BY REGISTRAR FEB 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

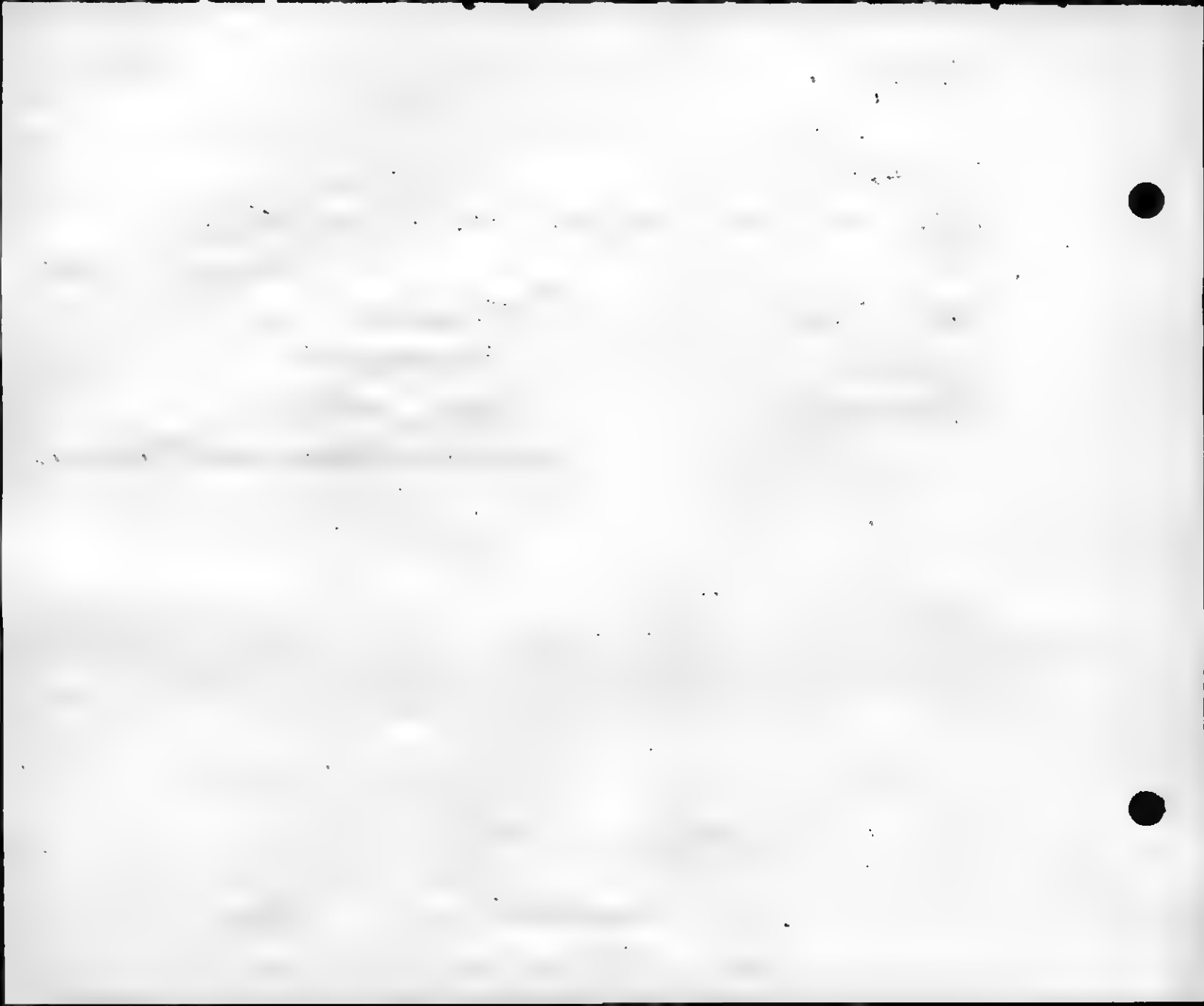
01780

01777

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>---</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>7th Avenue</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Veteran Administration Hospital</i>		d. STREET ADDRESS <i>448 Pitman Place</i>	
3. NAME OF DECEASED (Type or print) <i>William J. DAVIS</i>		4. DATE OF DEATH <i>February 17 1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 28, 1928</i>
9. AGE (In years last birthday) <i>38</i> yrs.		10. AGE (In years last birthday) <i>38</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labored</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Travelling N.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>Greenville N.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Tom Davis</i>		14. MOTHER'S MAIDEN NAME <i>Nina Staniel</i>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <i>---</i>		16. SOCIAL SECURITY NO. <i>---</i>	
17. INFORMANT <i>Alvin, Rec. Vpt Adm. Hsp't Hagerstown</i>		Address <i>---</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Failure</i> DUE TO (b) <i>2nd + 3rd Degree Burns</i> DUE TO (c) <i>Back, arms & Hands</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>2 wks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>---</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>2/2 1967</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Baltimore</i> (County) <i>---</i> (State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Theo C. Patterson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>THEO. C. PATTERSON</i>		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>2/21/67</i>	
Address (Street, city, town, or county) <i>---</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>Feb 21/67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Bethel Hall Cem.</i>		23d. LOCATION (City, town or county) <i>Balto MD</i> (State) <i>---</i>	
24. FUNERAL DIRECTOR <i>Walter E. Glicker</i>		ADDRESS <i>1129 N. Carroll</i>	
25a. REC'D BY REGISTRAR <i>---</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>FEB 24 1967</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.




MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

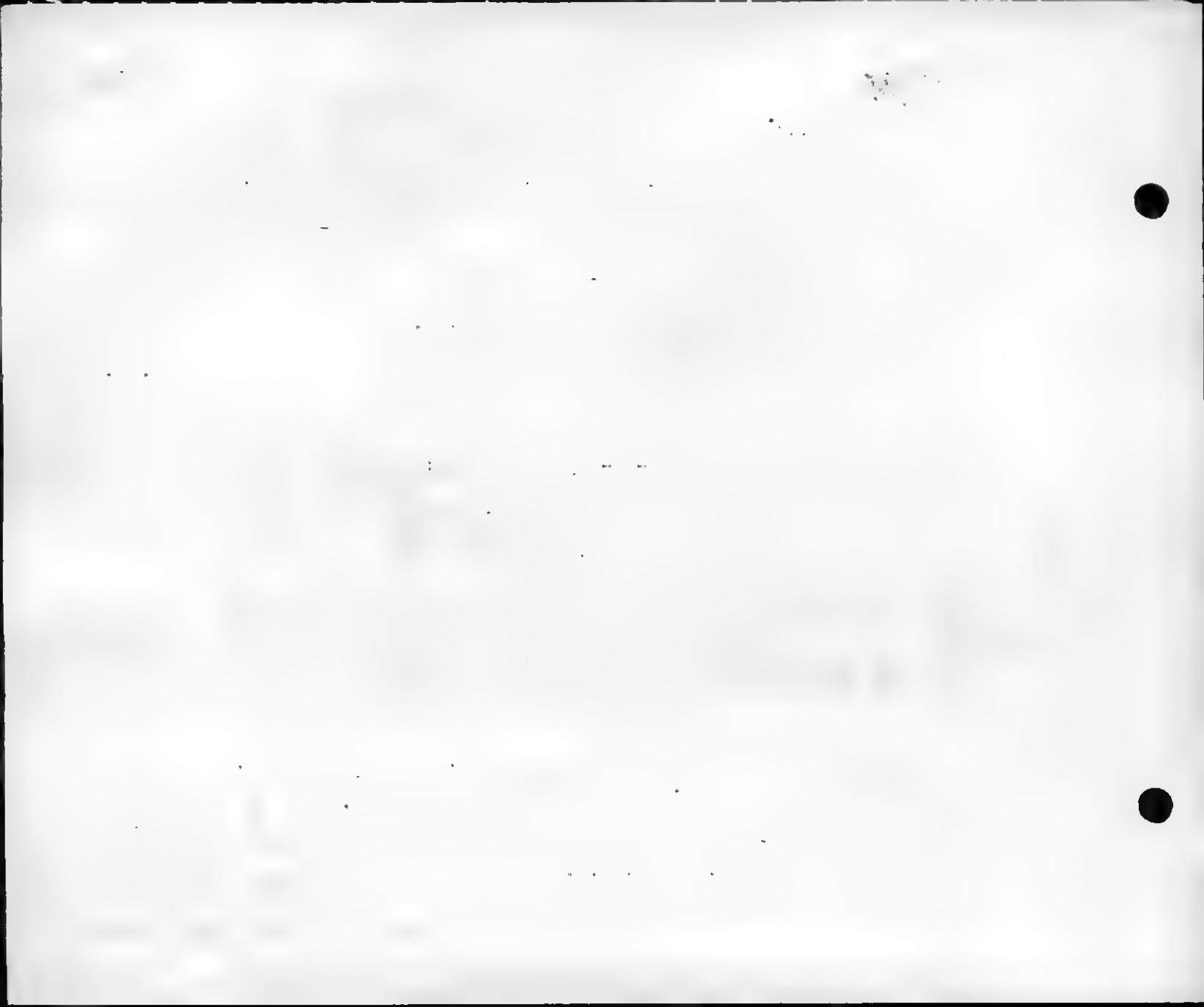
01781

01778

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville			c. LENGTH OF STAY IN 1b 1yr3mth14dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Route 15 - Box 712		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle L. Last Delanty				4 DATE OF DEATH Month February Day 3 Year 1967			
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 6, 1900		9 AGE (In years last birthday) 66 yrs	10 UNDER 1 YEAR Months 6 Days 14	11 UNDER 24 HRS Hours 14 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Ohio		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John McGinty				14. MOTHER'S MAIDEN NAME Elizabeth Stauder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 706-16-7551		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism, acute 466X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis, right leg DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from Oct. 12, 1965 to Feb. 3, 1967 (that it (we) last saw the deceased alive on Feb. 3, 1967 , and that death occurred at 1:15 M, from causes and on the date stated above.							
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228		22b. DATE SIGNED 2-3-67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/7/67		23c. NAME OF CEMETERY OR CREMATORY Arlington Math.		23d LOCATION (City or Town) (County) (State) Arlington Md.	
24 FUNERAL DIRECTOR J. H. Connolly Son				25a REC'D BY REGISTRAR 300 More		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE FEB 7 1967				DATE FEB 7 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #3 Film 3-10-67

01782

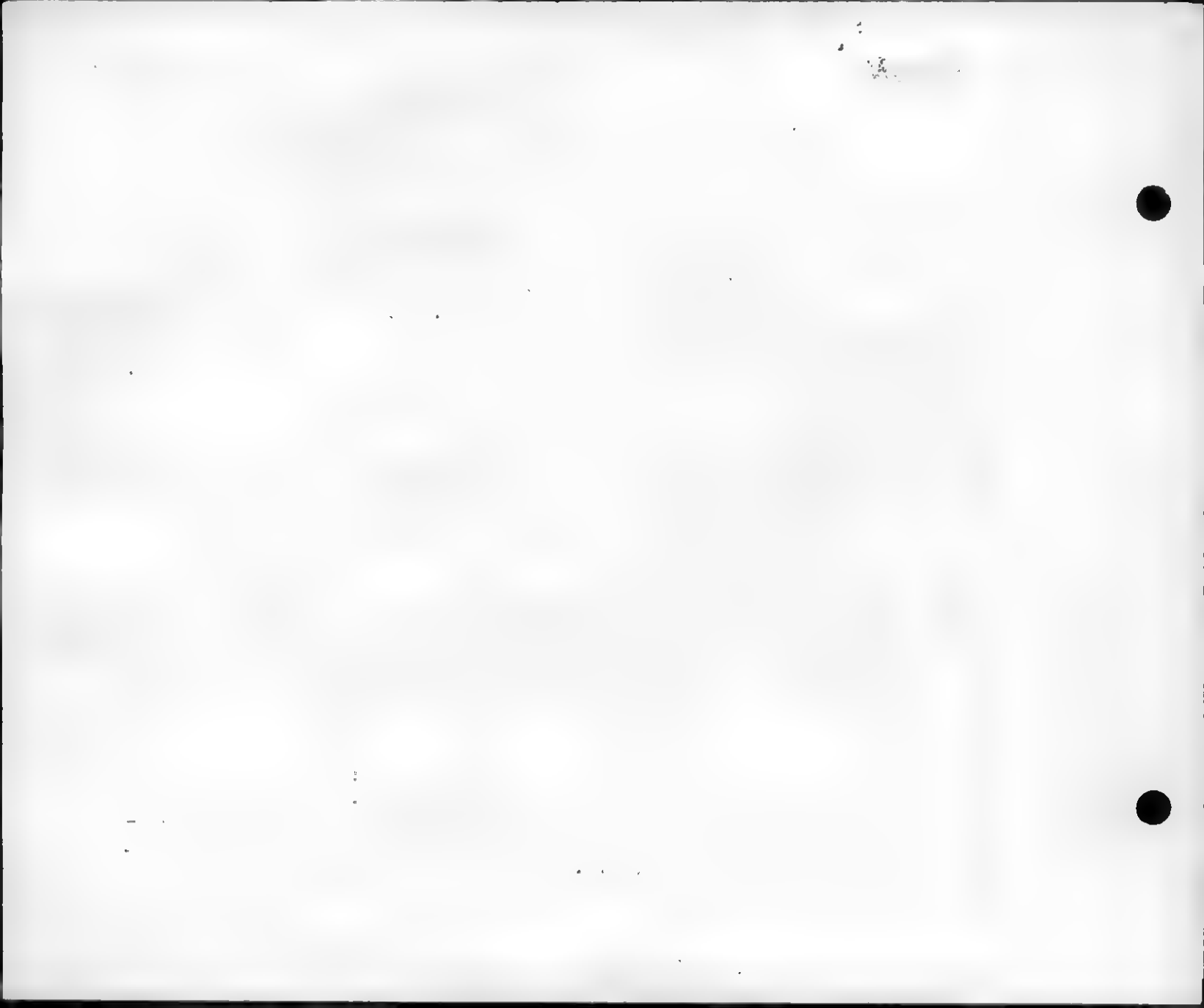
CERTIFICATE OF DEATH

03171

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 33yr10mth10dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1024 Denver Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Arthur Deiker a.k.a. Arthur Delcher				4. DATE OF DEATH Month February Day 27 Year 1967			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 20, 1899	
9. AGE (In years last birthday) 68 yrs		10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME George				14. MOTHER'S MAIDEN NAME Carrie Myers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Carcinoma of cecum							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from April 17, 1932 to Feb. 27, 1967 , that (I) last saw the deceased alive on Feb. 27, 1967 , and that death occurred at 2:30 M, from causes and on the date stated above.							
22a. SIGNATURE <i>Stella Wachslar</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-28-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL (CREMATION, REMOVAL) (Specify) RE		23b. DATE THEREOF II-7-67		23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR <i>Newell Funeral Home, Pikesville - 8-1114</i>				25a. REC'D BY REGISTRAR MAR 8 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01783					01779						
Item #23b											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Monkton - Avondale</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>York Road at Hereford</u>					d. STREET ADDRESS <u>York Road at Hereford</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jennie</u>		First		Middle		Last		4. DATE OF DEATH <u>February 11 1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/7/1885</u>		9. AGE (In years last birthday) <u>81</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Hereford, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Dr. Alexander Mitchell</u>					14. MOTHER'S MAIDEN NAME <u>Edith Stockton Conway</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. J. Elliott Mays, Avondale, Monkton, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4201</u> DUE TO (b) <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arterio Sclerotic C.V. Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>52</u> , to <u>2-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-10</u> , 19 <u>67</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Herbert Mueller Jr</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-11-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Dr. Herbert Mueller</u>					22d. ADDRESS <u>Parkton, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>					
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>						25a. REC'D BY REGISTRAR <u>DATE FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



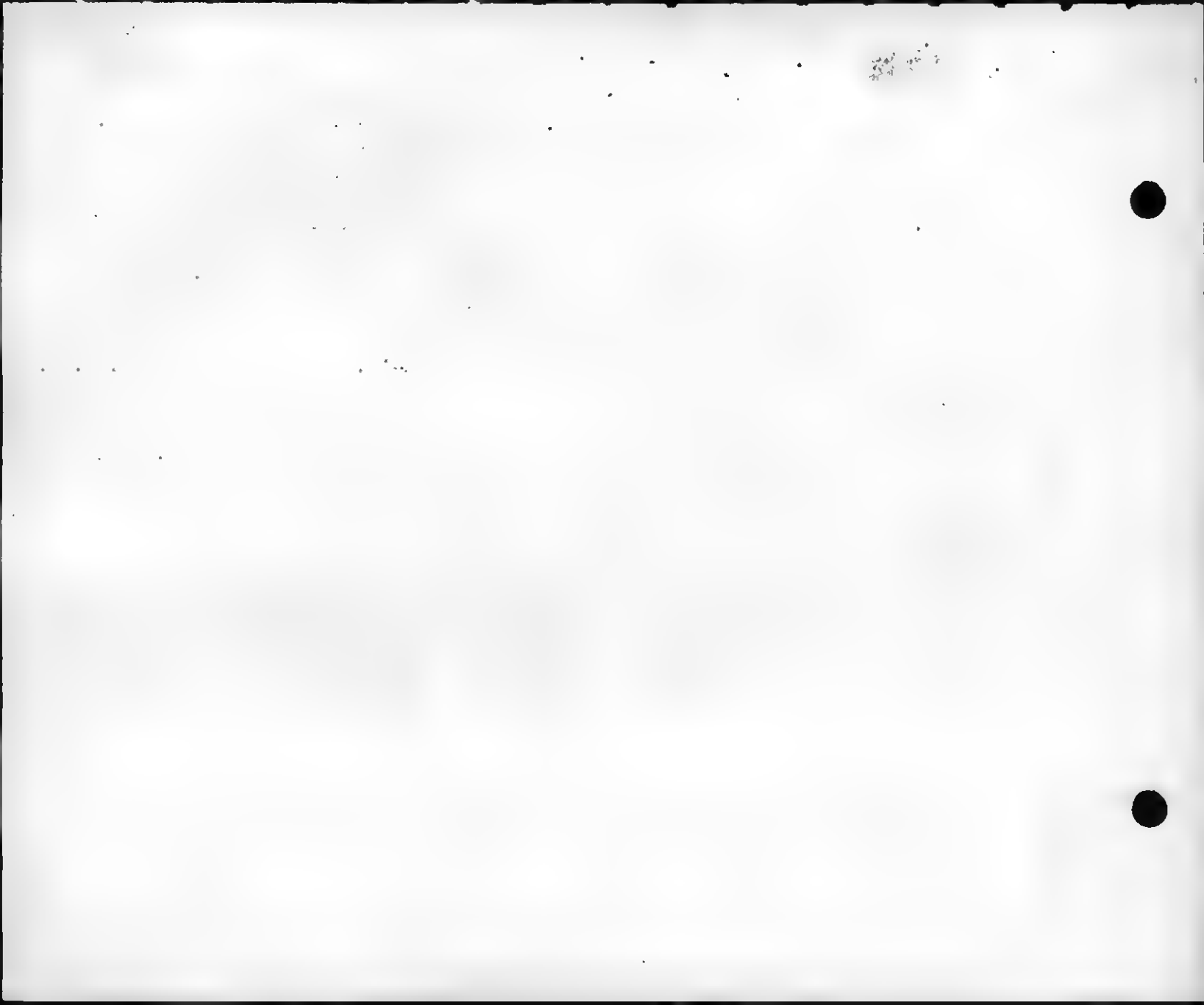
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 2 See birth cert. **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH **01780**

01784

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN IL 2 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Joseph		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 21212 d. STREET ADDRESS 1022 Woodson Road 7620 York Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jane Middle Renee Last Divine		4. DATE OF DEATH Month Feb. Day 21 Year 1967		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/2/67	
9. AGE (In years last birthday) 1 yrs. 21 Months 1 Days 21 Hours 1 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY 1	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Divine	
14. MOTHER'S MAIDEN NAME DORA DODSON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Parents		18. ADDRESS 1022 Woodson Rd. 21212		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE 1040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. _____		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20d. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from _____ , 19 _____ , to _____ , 19 _____ , that (I) (we) last saw the deceased alive on _____ , 19 _____ , and that death occurred at _____ M, from the causes and on the date stated above.		22a. SIGNATURE Jose A. Aguirre	
22b. PHYSICIAN'S NAME (Type) _____		22c. ADDRESS _____		22d. DATE SIGNED 2-21-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/22/67		23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS SWEET AIR	
23d. LOCATION (City, town or county) SWEET AIR, MARYLAND		23e. REC'D BY REGISTRAR Wm. Cook-Brooks		23f. REGISTRAR'S SIGNATURE Towson 1050 York Rd 21204	
24. FUNERAL DIRECTOR Wm. Cook-Brooks		24a. DATE FEB 23 1967		24b. SIGNATURE _____	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

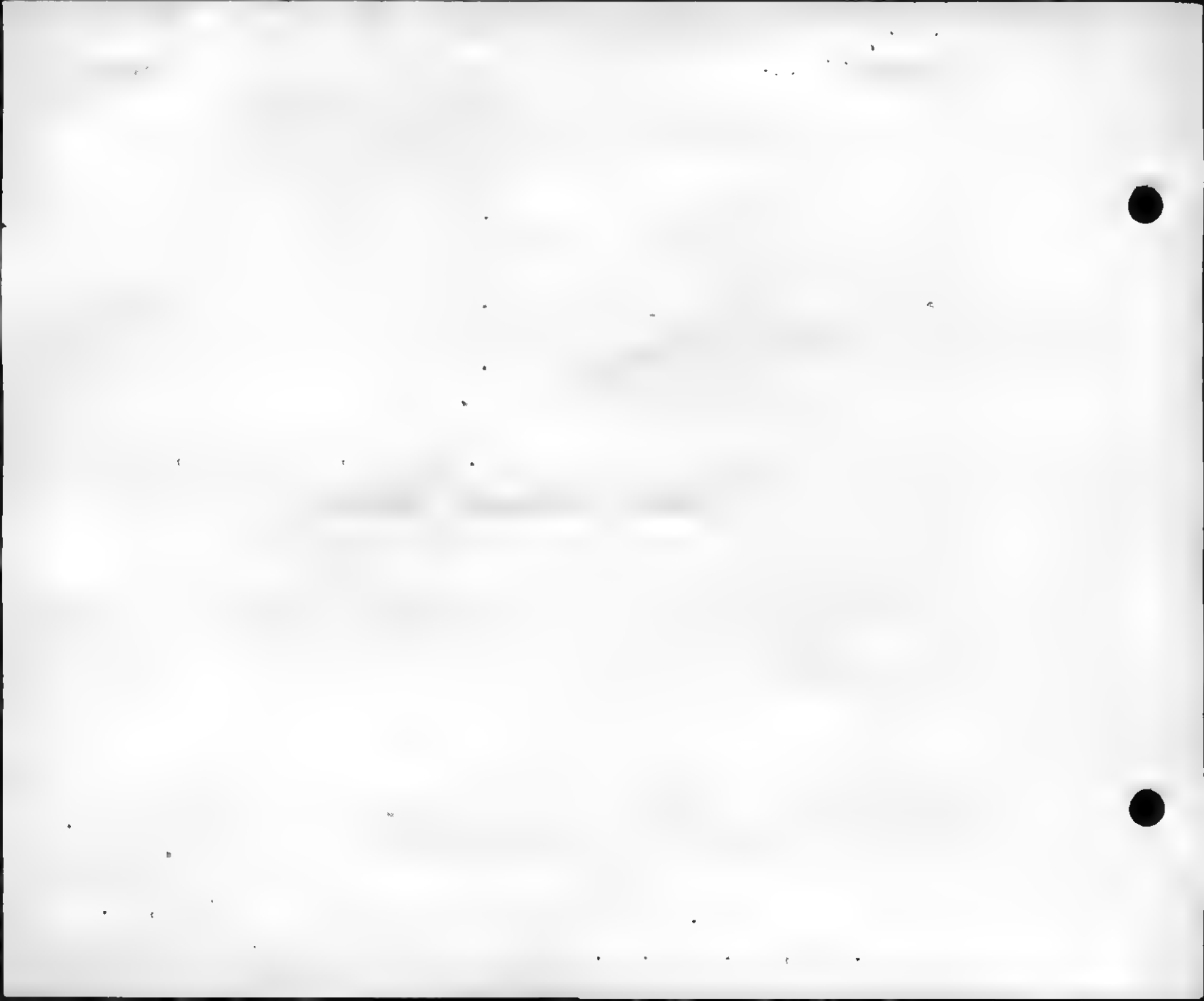
01785

CERTIFICATE OF DEATH

01781

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTO MED CENTER</u>		e. STREET ADDRESS <u>3133 E. MONUMENT ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EVELYN ELIZABETH DORMAN</u>		4. DATE OF DEATH Month Day Year <u>2-14-1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEP 29 1914</u>
9. AGE (In years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Trading Stamp Co.</u>	
11. BIRTHPLACE (County & State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EUGENE MORRIS REINPOLLAR</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE ELIZABETH HINE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>080037024</u>	
17. INFORMANT <u>Mrs. Gay Carls, 8134 Burnside, Hyattsville Md</u>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC CARCINOMA, STOMACH?</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVA. BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-24-67</u> , 1967, to <u>2/14/</u> , 1967, that (I) (we) last saw the deceased alive on <u>2/14/</u> , 1967, and that death occurred at <u>1:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Arnold L. Field</u> M.D.		22b. DATE SIGNED <u>2/14/67.</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARNOLD L. FIELD, M.D.</u>		22d. ADDRESS <u>901 Cathedral H Bldg. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/17/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>FEB 16 1967</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

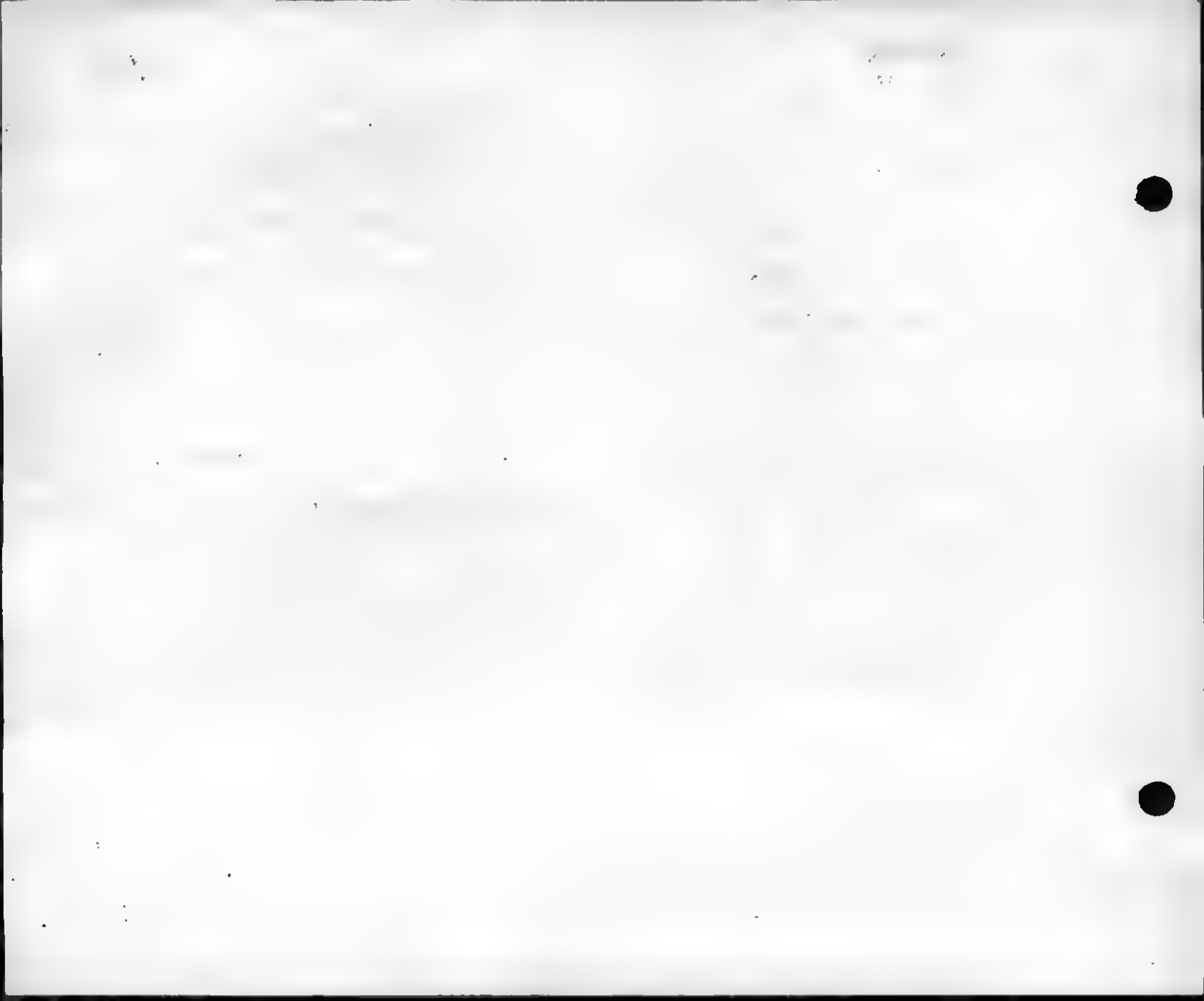
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01786

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01782

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson c. LENGTH OF STAY IN b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland d. STREET ADDRESS 322 North Fulton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle Dotson Last Dotson 4. DATE OF DEATH Month February Day 27 Year 1967		5. SEX Female 6. COLOR OR RACE colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH June 1, 1914 9. AGE (In years, log birthday) 52 yrs. IF UNDER 1 YEAR: Months 5 Days 27 IF UNDER 24 HRS: Hours 11 Min 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY housewife 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO no 17. INFORMANT Franklin Sq. Hosp. Records, Balto., Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Pulmonary Tuberculosis, adv. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) none DUE TO (c) none INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) none		20c. TIME OF INJURY Month, Day Year Hour a.m. none p.m. none 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples M.D. EXAMINER'S NAME (Type) D. D. Caples, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED 2/27/67 Address (Street, city, town, or county) Reisterstown, Md.	
23a. BURIAL (REMOVAL OR CREMATION) REMOVED 23b. DATE THEREOF 3/1/67 23c. NAME OF CEMETERY OR CREMATORY Reisterstown, Md. 23d. LOCATION (City or Town) (County) (State) Reisterstown, Md.		24. FUNERAL DIRECTOR Thomson Williams Funeral Home, 319 N. Schrader St., Balto., Md. 25a. REC'D BY REGISTRAR MAR 2 1967 25b. REGISTRAR'S SIGNATURE Charles J. Jones	

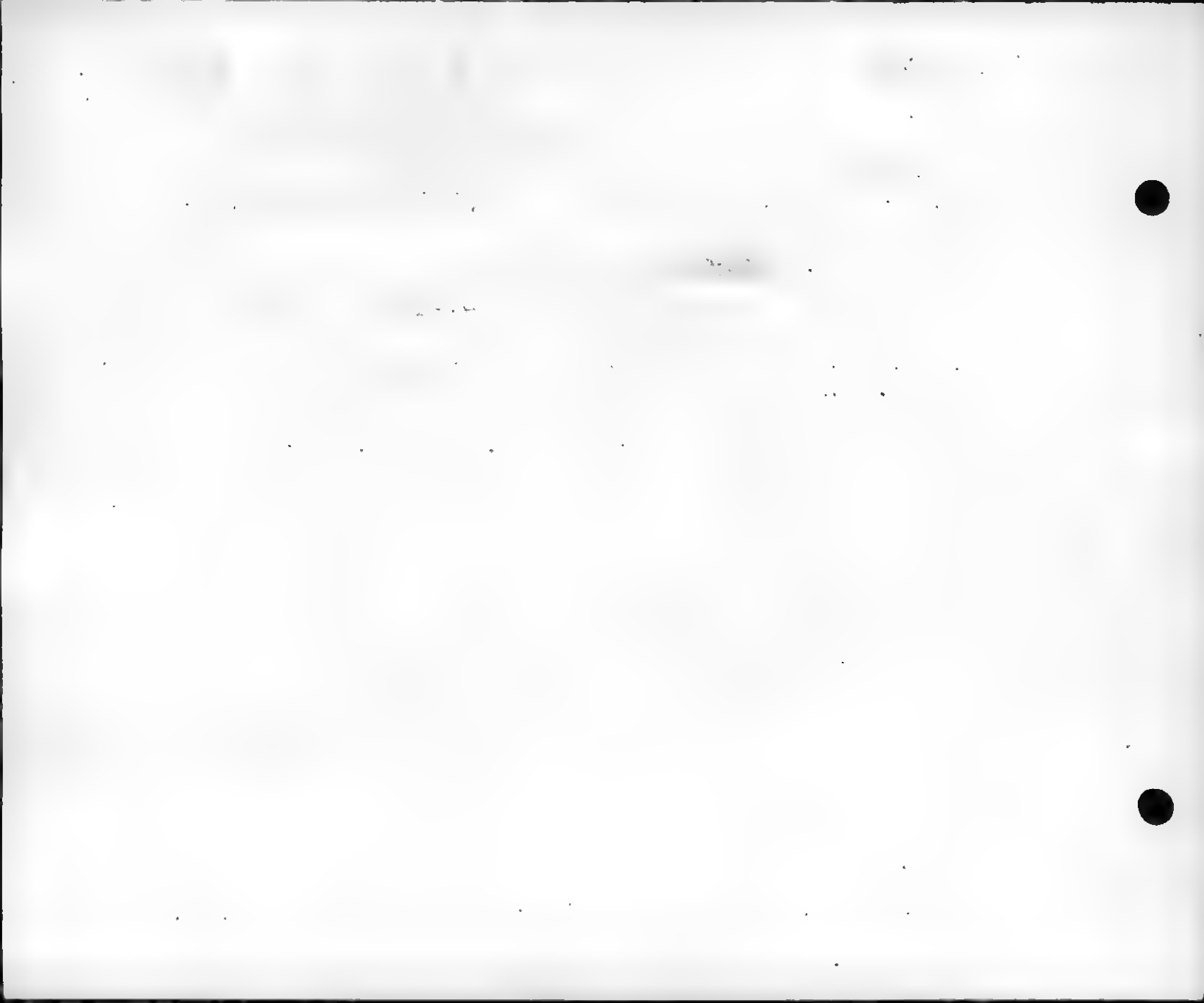


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01787					01783				
1. PLACE OF DEATH a. COUNTY Baltimore, Maryland b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN ID 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dulaney Towson Nursing and Convalescent					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 710 Walker Avenue 21212 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Home Middle Lillie Last Dunaway			4. DATE OF DEATH Month 2 Day 12 Year 1967						
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/26/1888		9. AGE (in years last birthday) 78 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tel. Operator			10b. KIND OF BUSINESS OR INDUSTRY C&P Tel. Co.			11. BIRTHPLACE (County & state, or foreign country) Lancaster Co. Va.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James P. Moore			14. MOTHER'S MAIDEN NAME Va. Smith						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Leonard P. Patterson		Address same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO cardi Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension cardio-vascular disease DUE TO 10 years (c) 10 years									INTERVAL BETWEEN ONSET AND DEATH 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from January, 1966 to February 12, 1967 , that (I) (we) last saw the deceased alive on February 9, 1967 , and that death occurred at 2:10 a.m. from the causes and on the date stated above.									
22a. SIGNATURE A. Allan Smith					22b. DATE SIGNED 2/12/67		22c. PHYSICIAN'S NAME (Type) A. Allan Smith		
22d. ADDRESS Bethel Methodist Cemetery Lively, Va.					22e. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION REMOVAL (Specify) Removal			23b. DATE THEREOF 2/13/1967		23c. NAME OF CEMETERY OR CREMATORY Bethel Methodist Cemetery		23d. LOCATION (City, town or county) (State) Lively, Va.		
24. FUNERAL DIRECTOR Wm. J. Tinkner & Son			25a. REC'D BY REGISTRAR Balto, Md. North Pa.		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 14 1967		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

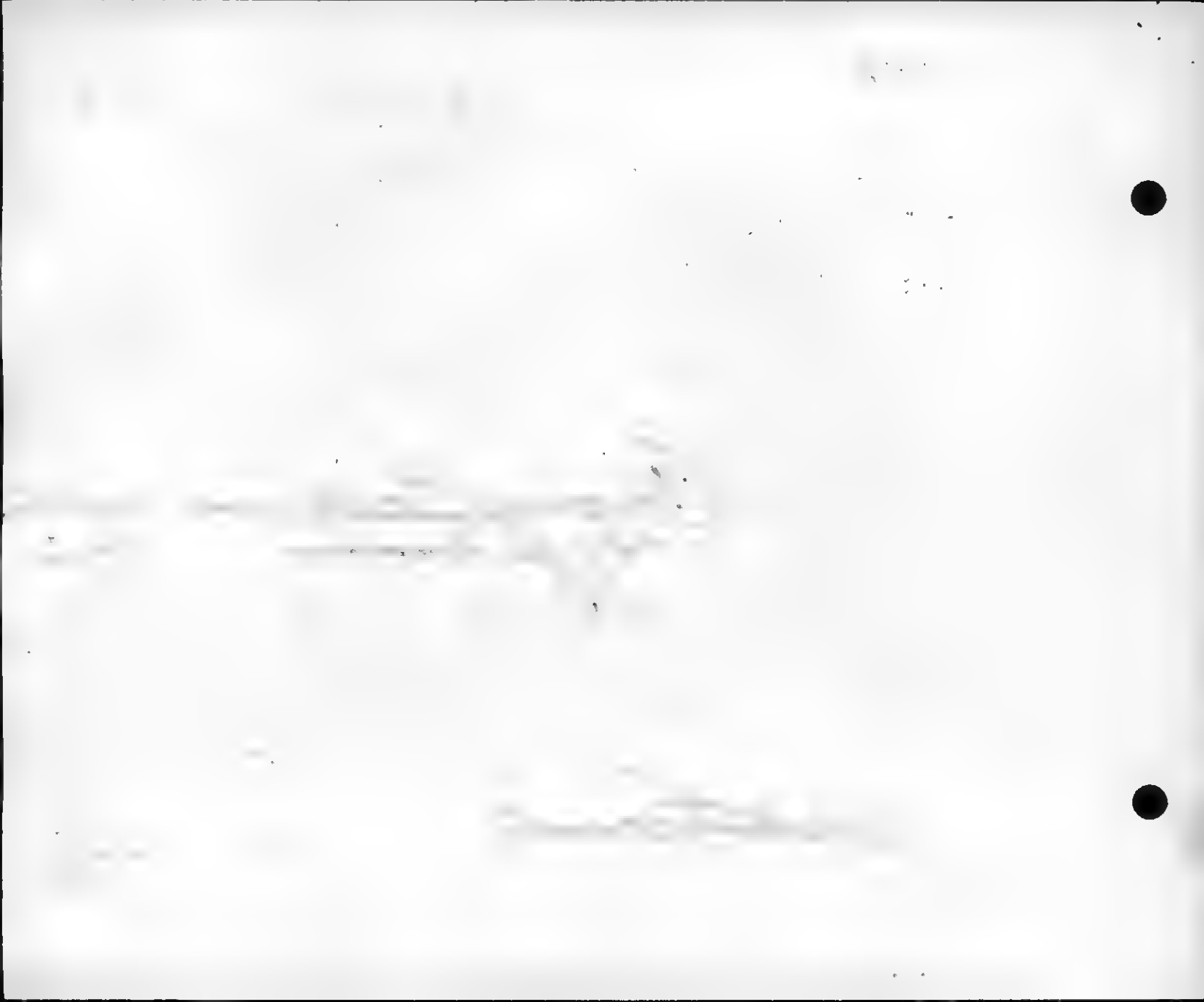
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01788

01784

1 PLACE OF DEATH a. COUNTY Balto MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Md. b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Parkville		c. LENGTH OF STAY N 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hosp.		e. STREET ADDRESS 8609 Wendel ave.	
3. NAME OF DECEASED (Type or print) JOHN J DURNER		4 DATE OF DEATH Feb 7 1967	
5. SEX M	6. COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 29 1905
9 AGE (In years last birthday) 61 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer	
10b. KIND OF BUSINESS OR INDUSTRY 20th Cen Press		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME John Durner	
14 MOTHER'S M A D E N NAME Margaret Mueller		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOC. A. SECURITY NO. 217-01-7024		17 INFORMANT Famiy records	
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4X01 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) By pericardium DUE TO (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden 59+	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 8)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D. EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		22. DATE SIGNED 2/7/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/67	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		23d. LOCATION (City or town) (County) (State) Balto Md.	
24 FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road		25a. REC'D BY REGISTRAR Feb 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

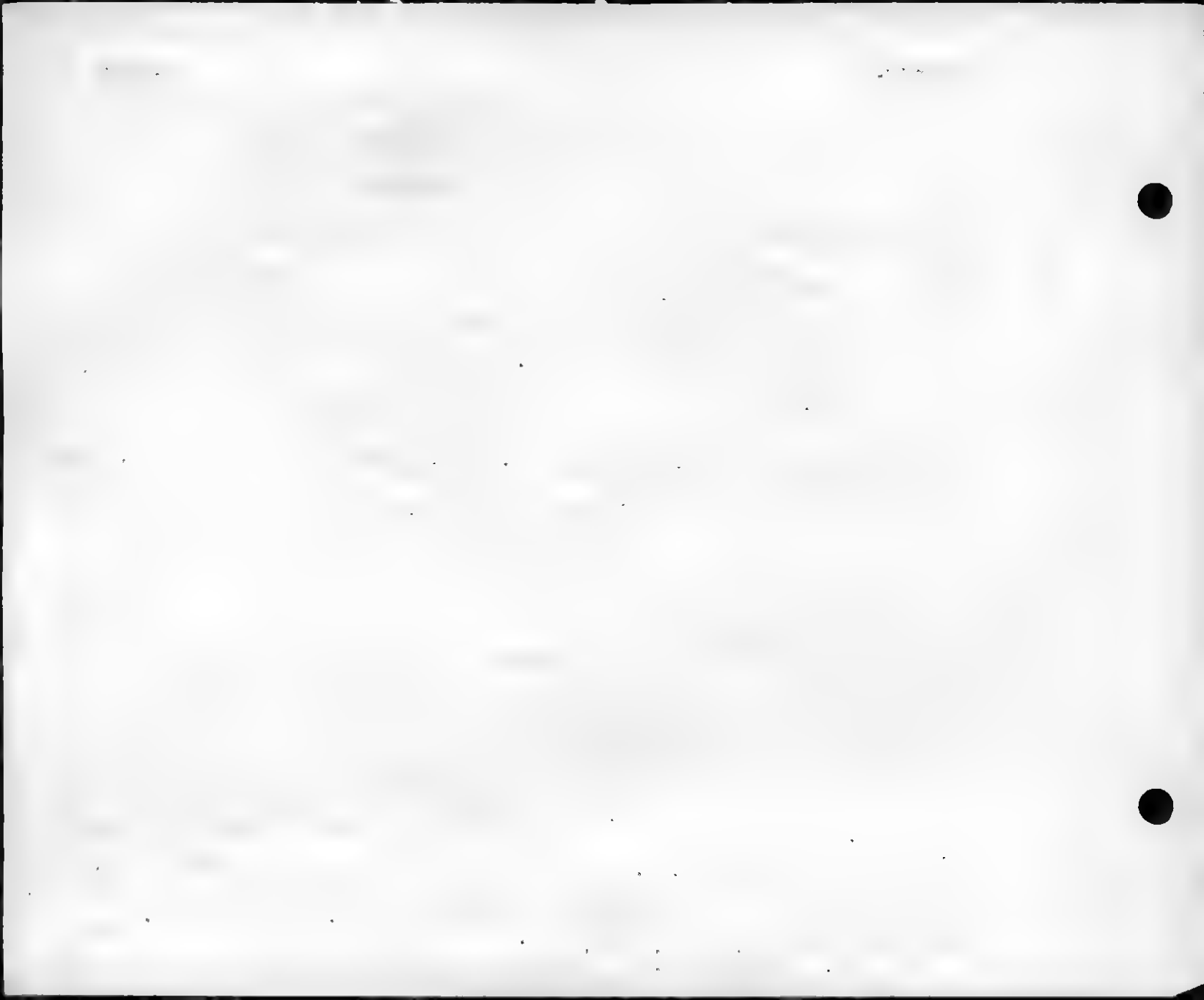
01789

CERTIFICATE OF DEATH

01785

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Towson			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21205		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 3108 McEldry Street		
3 NAME OF DECEASED (Type or print) Wallace William Eckert			4 DATE OF DEATH February 5, 19 67		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH January 7, 1893		9 AGE (In years last birthday) 74 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Maker		10b. KIND OF BUSINESS OR INDUSTRY City of Balto.		11 BIRTHPLACE (County & State, or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.			13 FATHER'S NAME unknown		
14. MOTHER'S MAIDEN NAME unknown			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		
16. SOCIAL SECURITY NO. 220-03-3569			17. INFORMANT Address J. Claire Hewitt Eckert, wife, above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Cardiovascular insufficiency DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of lung					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nor While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE <i>Juan G. Gan</i>		M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Juan G. Gan, M. D.		22d. ADDRESS 7620 York Road, Towson 4, Md.		22b. DATE SIGNED 2-5-1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/8/67	23c. NAME OF CEMETERY OR CREMATORY Baust United Church Cem. Tyrone, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Schlimmek Funeral Home, Inc. 2601 E. Madison St.			25a. REC'D BY REGISTRAR DATE FEB 7 1967		
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

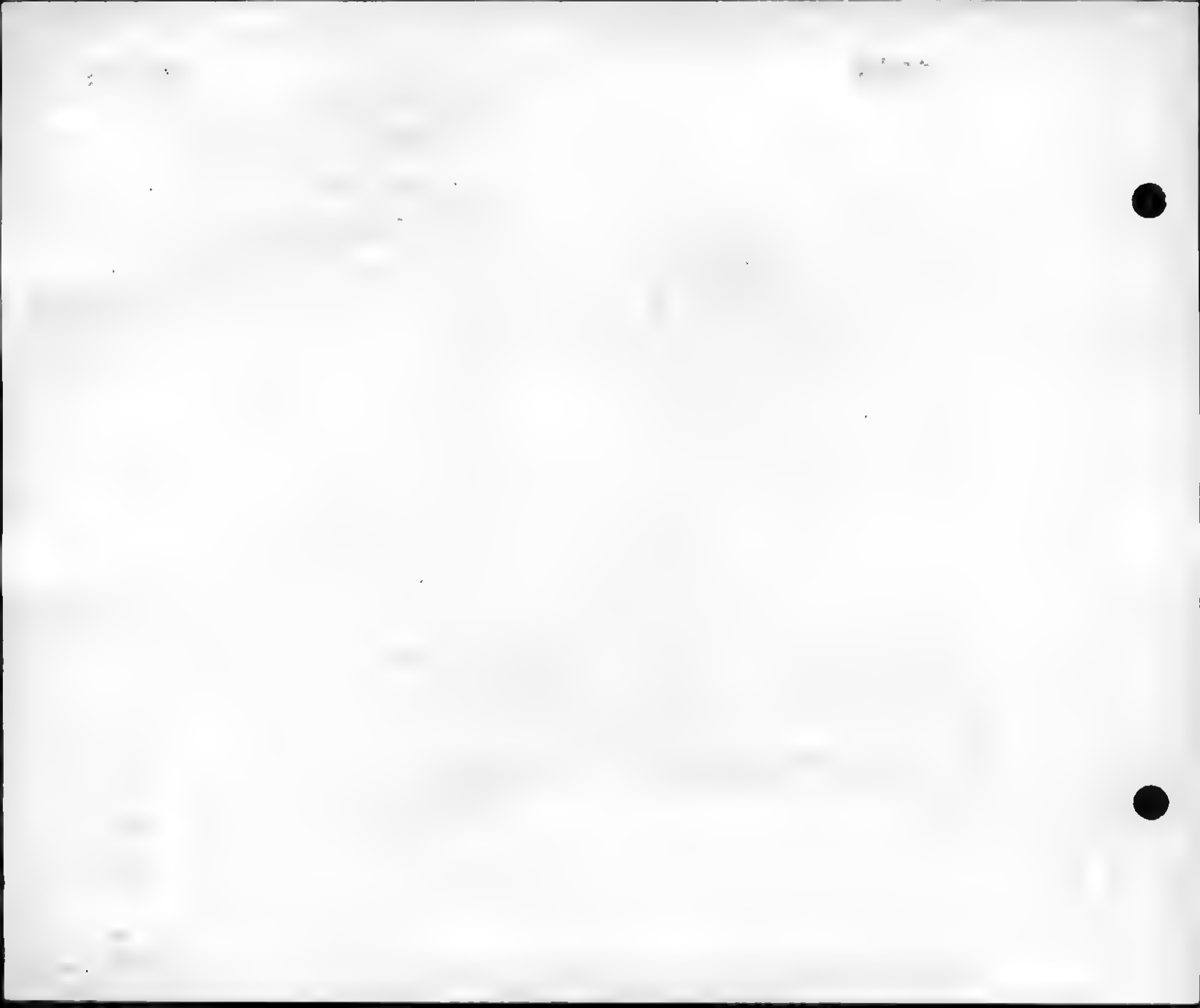
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01790

CERTIFICATE OF DEATH

01796

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 1829 Wilson Point Rd. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21220 d. STREET ADDRESS 1829 Wilson Point Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John F. EIMER SR.		4. DATE OF DEATH Month Day Year February 23, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1920
9. AGE (In years last birthday) 46		10. FUNDING YEAR Months Days Hours Min 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLARENCE W.		14. MOTHER'S MAIDEN NAME MILLIE RUDOLPH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) LINK		16. SOCIAL SECURITY NO. 213-18-3684	
17. INFORMANT CYNTHIA EIMER		Address ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS ALTPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/17/1967 , to 2/23/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/23/1967 , and that death occurred at 1 P.M. from causes and on the date stated above.			
22a. SIGNATURE Regalado T. Dizon		22b. DATE SIGNED February 23, 1967	
22c. PHYSICIAN'S NAME (Type) Regalado T. Dizon, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/27/67	
23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION (City or town) (County) (State) BALTO MD.	
24. FUNERAL DIRECTOR J. E. CONNELLY SONS		25a. REC'D BY REGISTRAR 300 MACE	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 28 1967	



TO DISPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

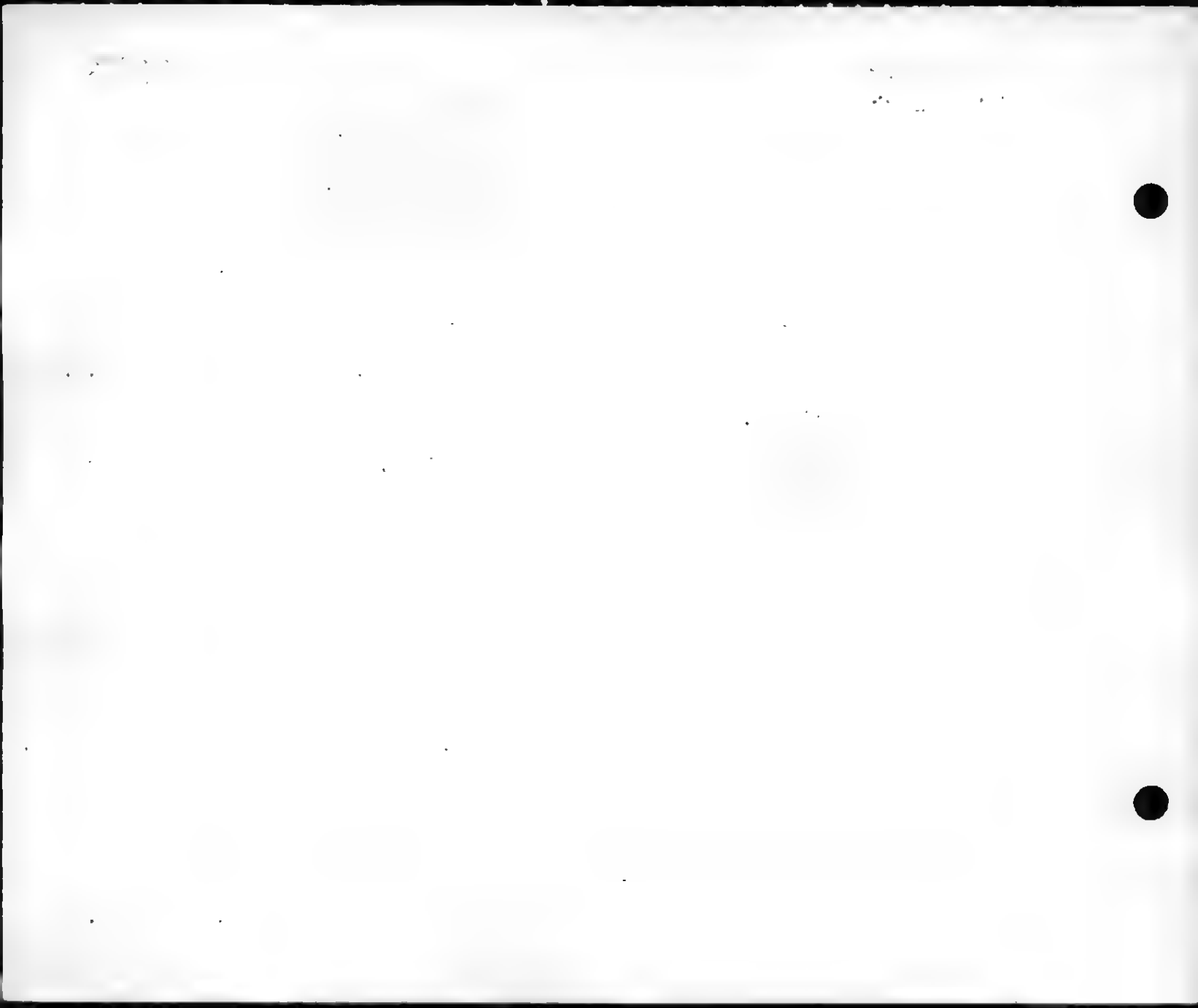
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01791

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01787

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golden Ring Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golden Ring Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8313 Allison Lane				d. STREET ADDRESS 8313 Allison Lane off Kenwood Road			
3. NAME OF DECEASED (Type or print) First MARTIN Middle HENRY Last ELLIGSON				4. DATE OF DEATH Month February Day 1 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-7-1907	9. AGE (In years last birthday) 60 yrs	10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min 0		11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Armco		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William P. Elligson				14. MOTHER'S MAIDEN NAME Barbara Lightner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-7631		17. INFORMANT Address Mrs Elsie L. Elligson 8318 Allison Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Contact Gunshot Wound of Head DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) App. Shot self.					
20c. TIME OF INJURY Month, Day, Year ? p.m. 2 1 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Basement		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breiteneker		EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2/2/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-4-1967		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road				25a. REC'D BY REGISTRAR DATE FEB 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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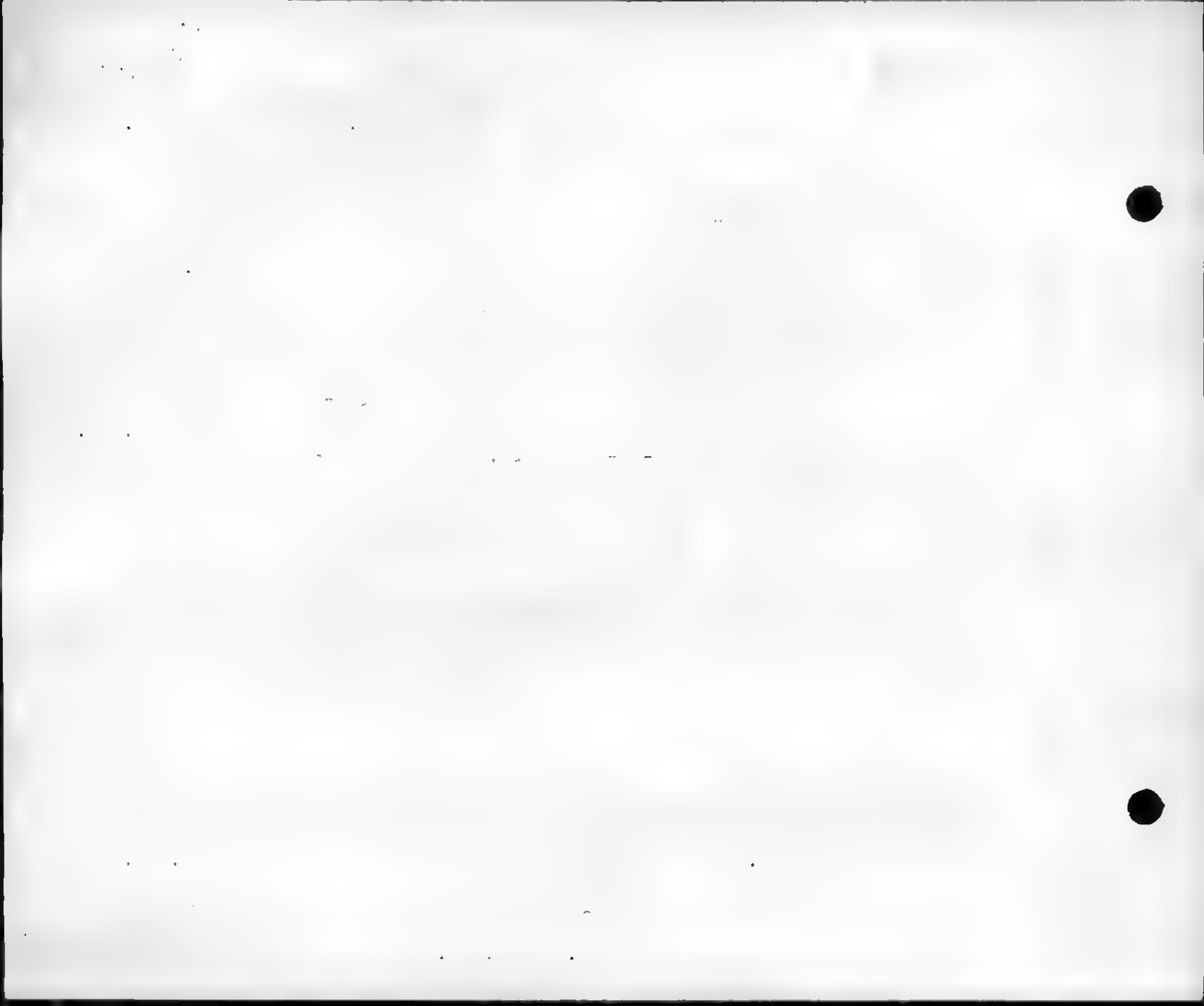
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 11, 12 Form 3506 1/5/67 mn

01792

CERTIFICATE OF DEATH

01738

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1215 Homberg Avenue - 21221				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex d. STREET ADDRESS 1215 Homberg Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Daisy Middle May Last Elza				4 DATE OF DEATH Month Feb. Day 18 Year 19 67			
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-26-09	9 AGE (In years last birthday) 57 YRS	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Bowden, West Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Earl Arbogast				14. MOTHER'S MAIDEN NAME Mary -			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO (If yes give war or dates of service) 234-44-4843		17. INFORMANT Mrs. Bernice Rowan-205 Linwood Ave-21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure DUE TO (b) Cancer of the gall bladder and liver DUE TO (c) (Exploratory laparotomy in January, 1967) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH few hours 2 months	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) None						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 2/10 , 19 67 , to 2/18 , 19 67 , that (I) (we) last saw the deceased alive on 2/18 , 19 67 , and that death occurred at 10:30 M, from causes and on the date stated above							
22a. SIGNATURE Eugene C. Baumann		22b. DATE SIGNED 2-19-67		22c. PHYSICIAN'S NAME (Type) Eugene C. Baumann			
22d. ADDRESS 413 Eastern Avenue, Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-22-67	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery	23d. LOCATION (City or Town) Elkins, West Virginia	(County)	(State)		
24. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Ave. Balto., Md.		25a. REC'D BY REG. STRAR DATE B 24 1967	25b. REGISTRAR'S SIGNATURE Charles J. Jones				



1
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01793					01789					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY		BALTIMORE			a. STATE		MARYLAND			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		TOWSON			b. COUNTY		BALTIMORE			
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
GREATER BALTIMORE Medical Center					8206 TAMA CT.					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. AGE (in years last birthday)			
First Middle Last JEROME None ENGEL					February 8 1967		52 yrs.			
6. SEX		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR		
MALE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		JAN 8 1915		52 yrs.		Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Plastic Products					ENGEL		BALTIMORE MONTGOMERY MD.		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Executive LOUIS ENGEL					Reba FRIEDENBERG					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			
No					217-05-8166		Mrs. Elaine Engel, 8206 Tama Court #8			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA										
DUE TO (b) LYMPHOCYTIC LEUKEMIA										
DUE TO (c) LYMPHOCYTIC LEUKEMIA										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
INTERVAL BETWEEN ONSET AND DEATH 12 Days										
8 YEARS										
MEDICAL CERTIFICATION										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Jan 31, 1967, to Feb 8, 1967, that (we) last saw the deceased alive on Feb 8, 1967, and that death occurred at 9:45 AM, from the causes and on the date stated above.										
22a. SIGNATURE					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)			
T.C. Cullis MD					Feb 8, 1967		T. C. CULLIS			
22d. ADDRESS					22e. ADDRESS					
Greater Baltimore Medical Center					Greater Baltimore Medical Center					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial			2/9/67		Aitz Chaim		Baltimore, Maryland			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Sol Levinson & Bros. Inc., 6010 Reisterstown					DATE FEB 14 1967		Charles Judge			



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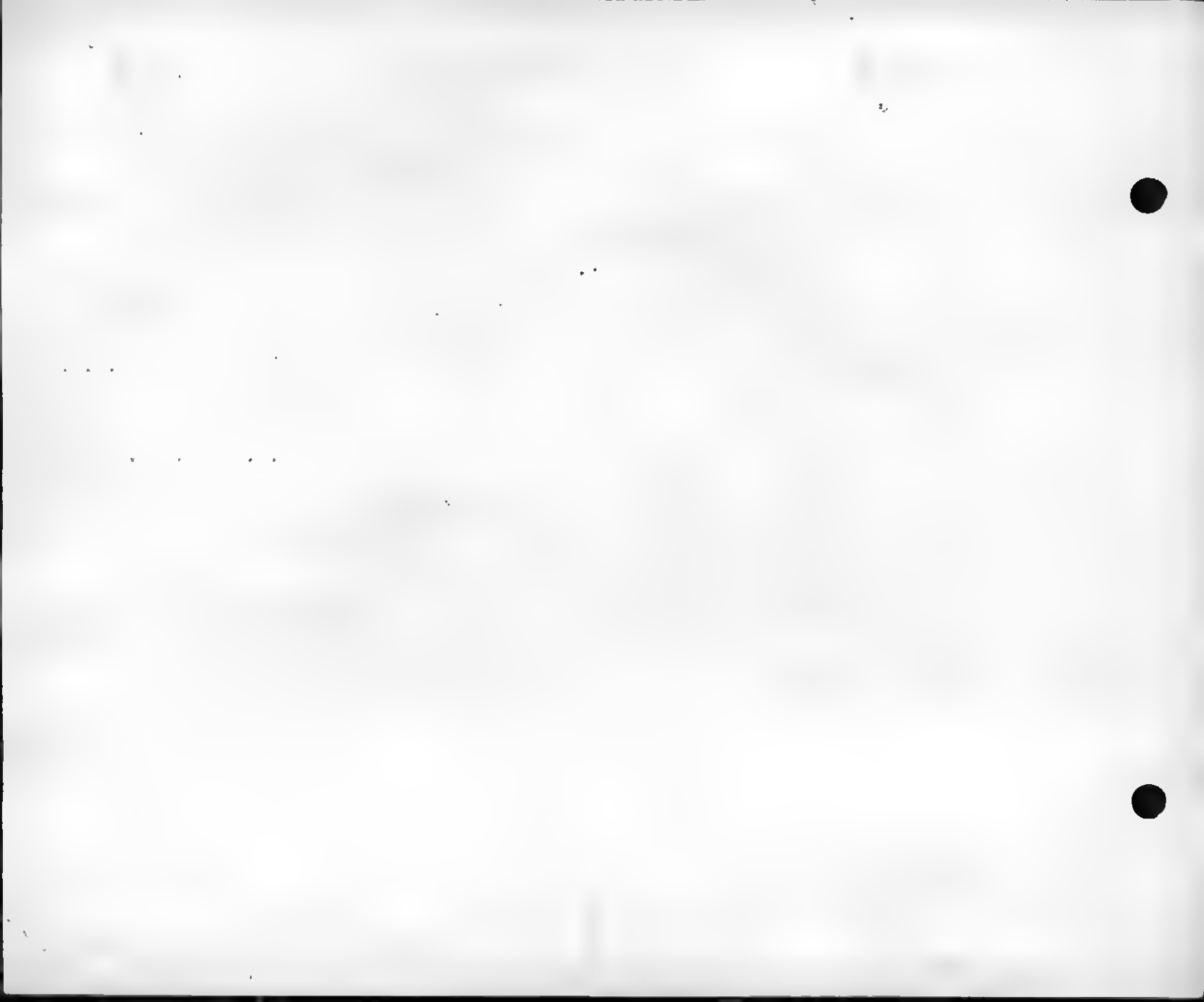
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2c & d Film #0386 3/15/67 pc

01794

CERTIFICATE OF DEATH

01790

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b Baltimore 21220			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ridgeway Manor Nursing Home				d. STREET ADDRESS 2123 Oakland Rd IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ada Middle L. Last Fair				4. DATE OF DEATH Month 2 Day 27 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-1874	9. AGE (In years last birthday) 92 yrs	IF UNDER 1 YEAR Months 2 Days 27	IF UNDER 24 HRS Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 285-34-7439A		17. INFORMANT Address Mr Otto Egner Chase P.O. Chase, Md. 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 day and
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1966 to 27 , 19 67 , that (I) (we) last saw the deceased alive on 27 Feb 1967 and that death occurred at 1030 AM , from causes and on the date stated above.							
22a. SIGNATURE William Goodman, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Mar 1, 67	
22c. PHYSICIAN'S NAME (Type) WILLIAM GOODMAN MD				22d. ADDRESS 1334 SLEEPY SPRING ROAD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-2-1967		23c. NAME OF CEMETERY OR CREMATORY Grand View Cemetery		23d. LOCATION (City or Town) (County) (State) Chillicote Ohio	
24. FUNERAL DIRECTOR ADDRESS (34) Lassah Funeral Home 7401 Belair Road				25. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

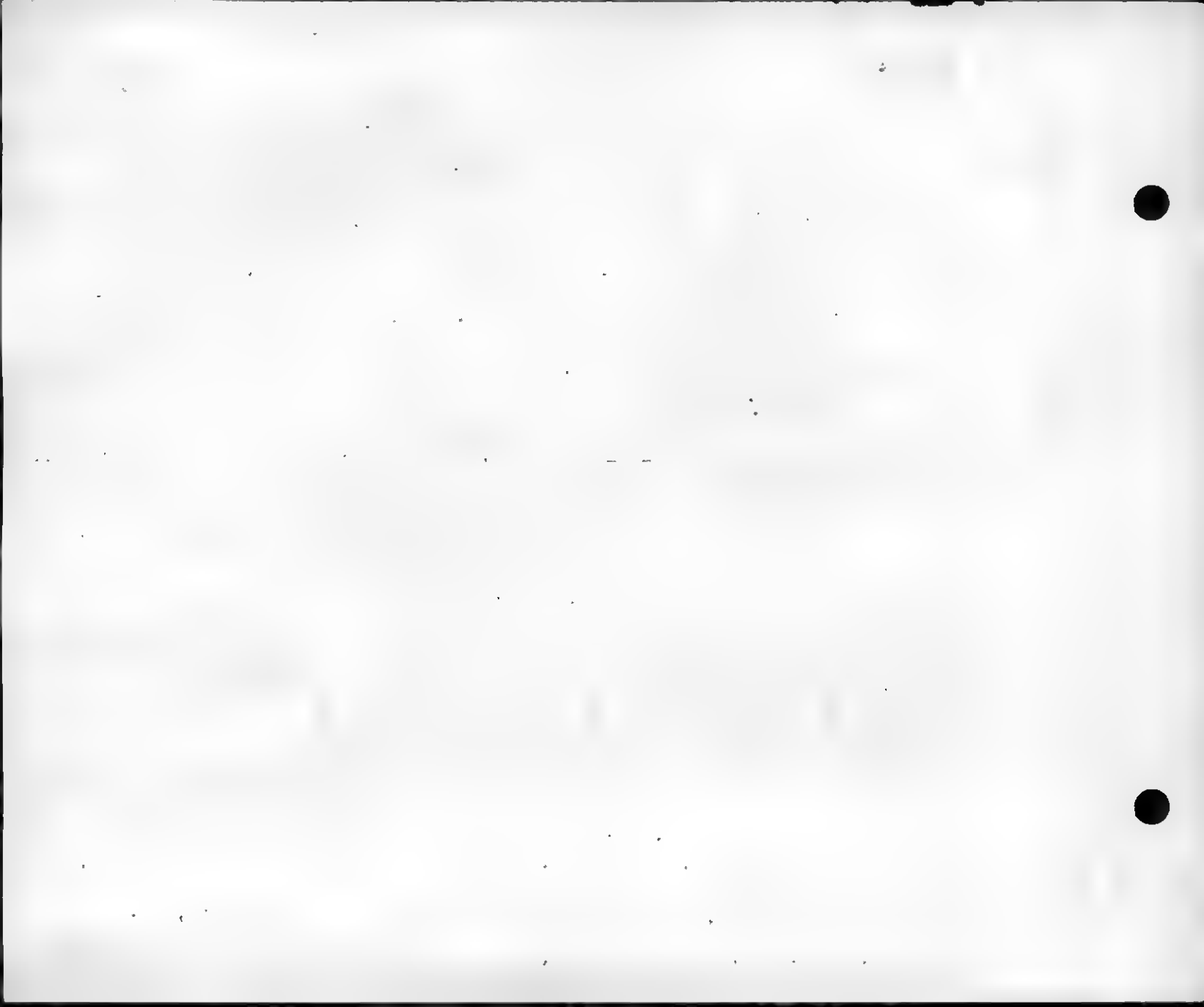


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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
01795						01791					
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 12-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1644 Hardwick Road						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204 d. STREET ADDRESS 1644 Hardwick Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GEORGE JOSEPH FAUSTMAN First Middle Last						4. DATE OF DEATH Month Day Year February 27 1967					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 21, 1914		9. AGE (in years last birthday) 53 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Luggage manager				10b. KIND OF BUSINESS OR INDUSTRY Korvette Co.		11. BIRTHPLACE (County & State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William F. Faustman						14. MOTHER'S MAIDEN NAME Anna Grandy					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 2				16. SOCIAL SECURITY NO. 213-05-7382		17. INFORMANT Address Mrs. Mary Read Faustman, 1644 Hardwick Rd., 4					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Coronary thrombosis, probable Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) History of acute Pulmonary edema (c) probably due to Coronary insufficiency										INTERVAL BETWEEN ONSET AND DEATH minutes 3 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from October 1963 , to February 1967 , that (I) (we) lost the deceased alive on 2-25-1967 , and that death occurred at 1A M, from causes and on the date stated above.											
22a. SIGNATURE William P. Benson, Jr.						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-27-67			
22c. PHYSICIAN'S NAME (Type) Dr. William P. Benson, Jr.						22d. ADDRESS 3506 N. Calvert St., Balto., 18					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/2/67.		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc.--Baltimore, Md.--14						25a. REC'D BY REGISTRAR DATE FEB 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL ON ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

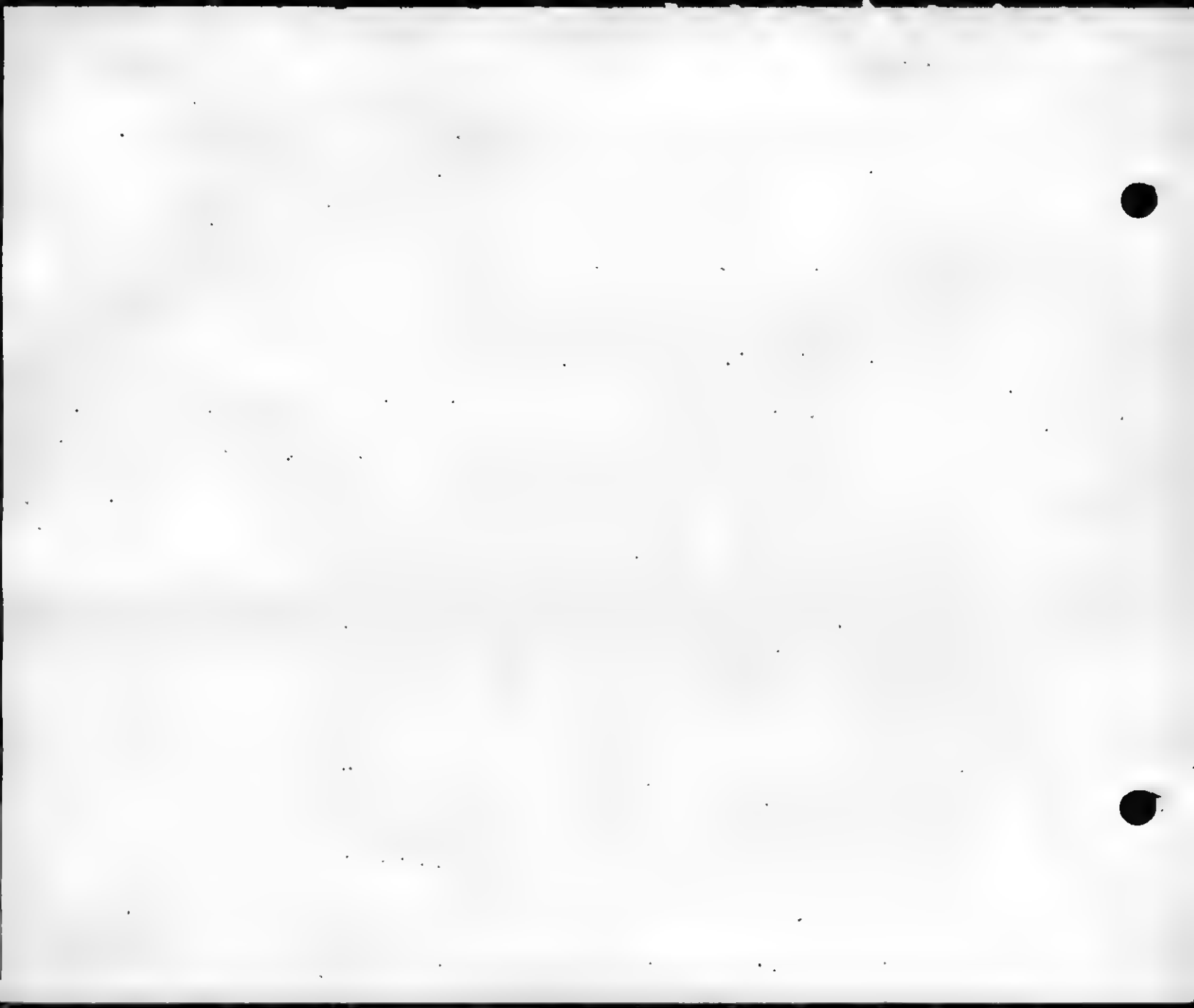
01796

CERTIFICATE OF DEATH

01792

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MD c. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 600 STONEY LANE		d. STREET ADDRESS 600 STONEY LANE	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS P. FAYA		4. DATE OF DEATH Month Day Year FEB. 17 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 29 1954
9. AGE (in years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mins.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. CONTRACTOR		11b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR	
11. BIRTHPLACE (County & State, or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HERMAN FAYA		14. MOTHER'S MAIDEN NAME MARY HOLTMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT WALTER P. FAYA		Address 600 1/2 STONEY LANE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.D. 4221 DUE TO (b) C.I.-C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Other conditions			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-1 , 19 65 , to 2-17 , 19 67 , that (I) (we) last saw the deceased alive on 2-17-67 , and that death occurred at 6 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE James E. Sowals		22b. DATE SIGNED 2-18-68	
22c. PHYSICIAN'S NAME (Type) James E. Sowals		22d. ADDRESS 1011 Frederick Rd - 28	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/20/67	
23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION (City, town or county) (State) BALTIMORE 28, MD.	
24. FUNERAL DIRECTOR FARLEY-CAVANAUGH		25a. REC'D BY REGISTRAR REC 20 1967	
25b. REGISTRAR'S SIGNATURE Charles			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

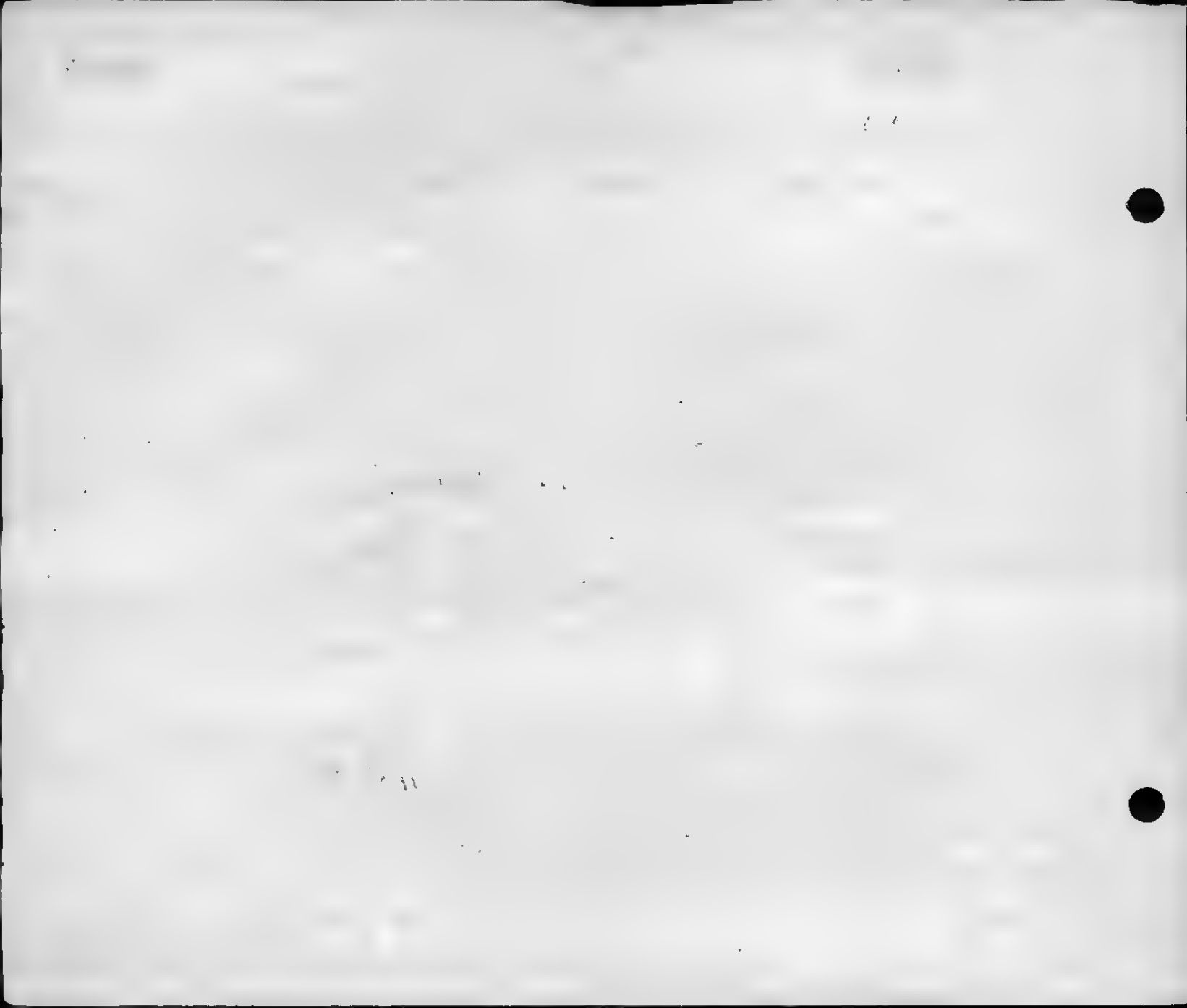
01797

01793

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PARADISE NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GREENBELT</u> d. STREET ADDRESS <u>PARKWAY</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN RAYMOND FUREY</u>		4. DATE OF DEATH Month <u>Feb</u> - Day <u>5</u> - Year <u>1967</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 JAN 1887</u>	9. AGE (In years last birthday) <u>80</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N. DAKOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>JOHN HENRY FUREY</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>397-01-6209</u>		17. INFORMANT <u>BETTRICE F. FUREY</u> Address <u>P.O. Box 123 GREENBELT, MARYLAND</u>			
18. CAUSE OF DEATH (Enter only one cause; but not for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis Right Hemisphere</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>Chronic Pain Syndrome</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10 yrs.</u> <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
2Da. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
2Dc. TIME OF INJURY Month, Day, Year Hour <u>19</u> p.m.	2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	2Df. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/5/67</u> to <u>2/5/67</u> that (I) (we) last saw the deceased alive on <u>2/5/67</u> and that death occurred <u>11:08 AM</u> on the causes and on the date stated above.							
22a. SIGNATURE <u>W. E. McGroth M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>2/5/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>W. E. McGroth M.D.</u>		22d. ADDRESS <u>1303 Frederick Rd Catonsville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-FEB-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Em.</u>	23d. LOCATION (City, town or county) <u>Beltsville, Maryland</u>	(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Riverdale, Md.</u>		ADDRESS	25a. REC'D BY REGISTRAR <u>FEB 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>W. E. Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

01798

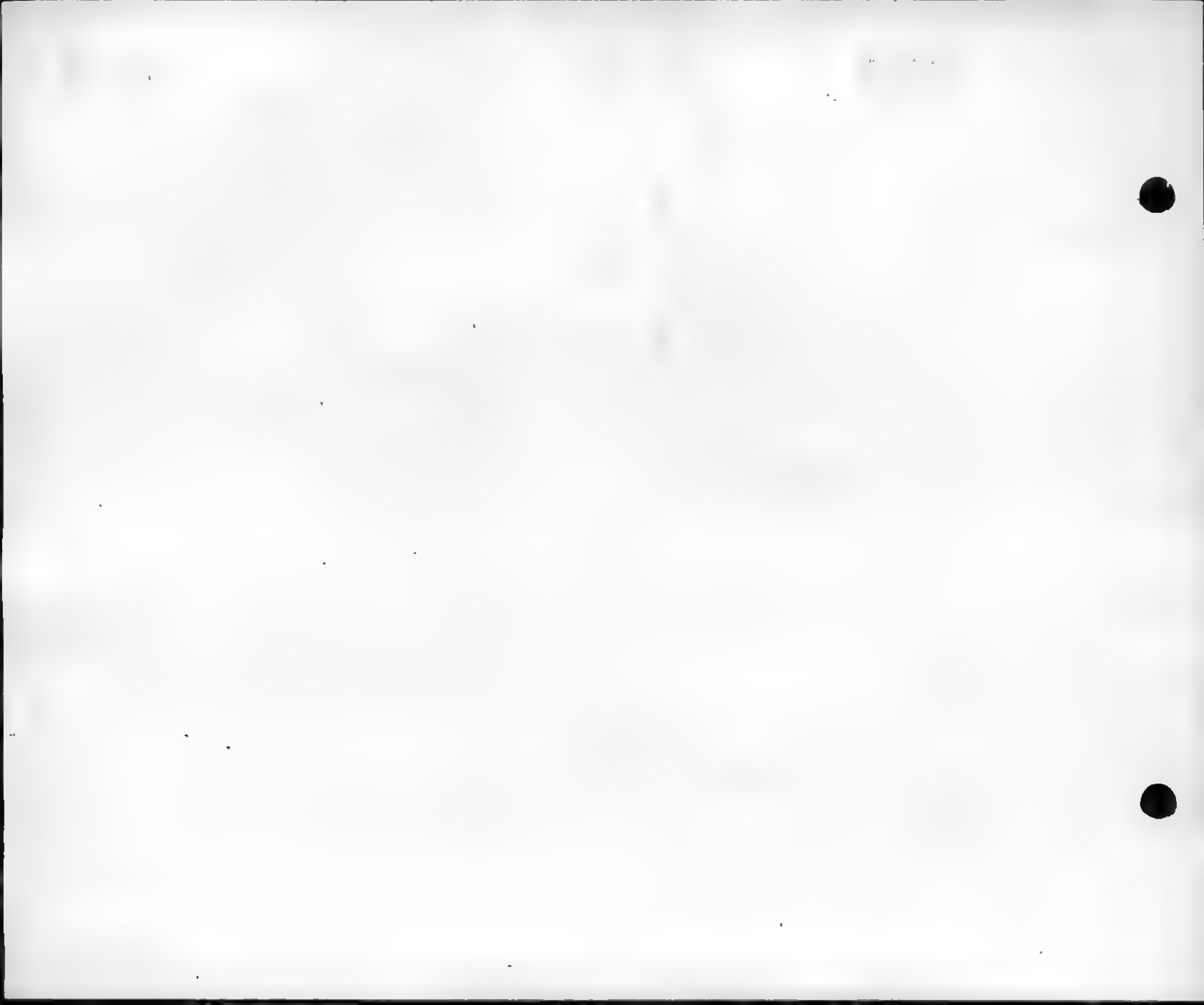
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01794

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not last on residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c LENGTH OF STAY IN 1b <u>Towson</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>St. Joseph's Hospital</u>		e STREET ADDRESS <u>Washington Avenue</u>	
3 NAME OF DECEASED (Type or print) First <u>John J.</u> Middle <u>Fielding</u> Last <u></u>		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1889</u>
9 AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Arsonist - Retired</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Daniel J. Fielding</u>		14. MOTHER'S MAIDEN NAME <u>Laura J. Fielding</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>None</u>		16 SOCIAL SECURITY NO. <u>217-07-3145</u>	
17 INFORMANT <u>Family records</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>Coronary Insufficiency</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		22. DATE SIGNED <u>2/7/67</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Feb. 10, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>St. Maria Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Towson, Maryland</u>
24 FUNERAL DIRECTOR <u>Go'n Jurns' Sons, Towson, Maryland</u>		25a REC'D BY REGISTRAR DATE <u>FEB 10 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles J. Jurns</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01799

01795

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore 21234		c. LENGTH OF STAY IN 1b 14 years Baltimore, Md. 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9606 Harding Avenue		e. STREET ADDRESS 9606 Harding Avenue	
3 NAME OF DECEASED (Type or print) First Walter Middle Levi Last Finch		4 DATE OF DEATH Month February Day 10 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 18, 1881
9 AGE (in years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembly		10b. KIND OF BUSINESS OR INDUSTRY Instrument	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME George Finch		14 MOTHER'S MAIDEN NAME Ruth Janes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-2267	
17. INFORMANT Mrs. LaVerne E. Doerer		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 171d DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH Sudden Several yrs. Approx. 1 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (do not) attended the deceased from July 6, 1960 to Feb. 6, 1967 , that (I) (was) lost saw the deceased alive on Feb. 6, 1967 , and that death occurred at 7:15A from causes and on the date stated above.			
22a. SIGNATURE <i>S.J. Liu</i>		22b. DATE SIGNED Feb. 13, 1967	
22c. PHYSICIAN'S NAME (Type) S.J. Liu, M.D.		22d. ADDRESS 5301 Harford Road	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/13/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.	23d. LOCATION (City or Town) (County) (State) Baltimore, Co., Md.
24 FUNERAL DIRECTOR 8521 Loch Raven B'lv.		25a. REC'D BY REGISTRAR DATE FEB 15 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the decedent's certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 11
10/1/72

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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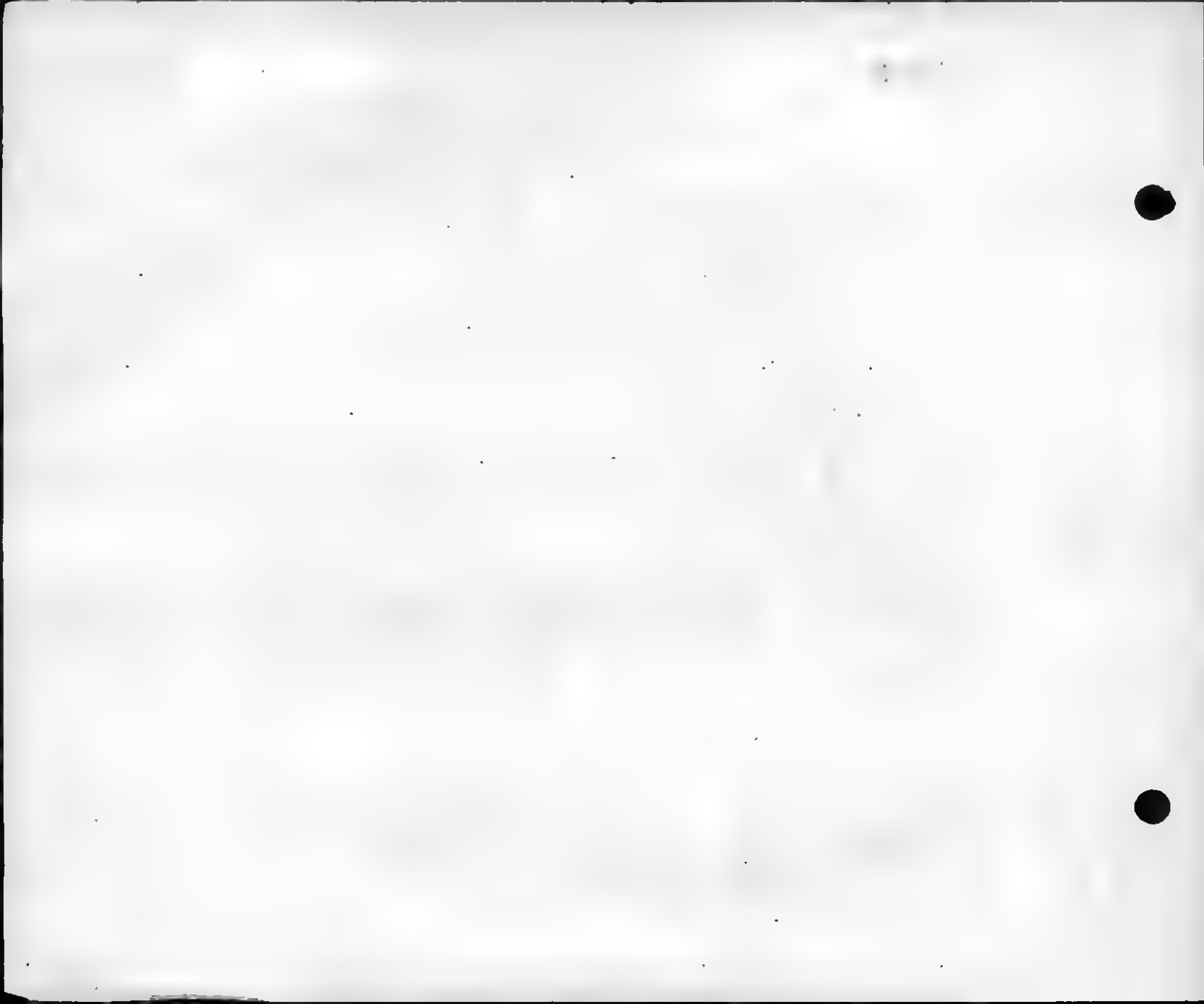
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01800

CERTIFICATE OF DEATH

01796

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b Years		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 814 Hathleigh Road		d. STREET ADDRESS 814 Hathleigh Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle S. Last FISHER		4. DATE OF DEATH Month February Day 23. Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1908
9. AGE (In years last birthday) 58 yrs		10. F UNDER 1 YEAR Months 12 Days 12 Hours 12 Min 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Vice Pres. & Treas.		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (County & State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edgar C. Fisher		14. MOTHER'S MAIDEN NAME Irene K. Schaeffing	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-03-2416	
17. INFORMANT Mrs. Ricka Fisher, Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs & 10 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MED CAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1936 , 19 67 , to 2/23 , 19 67 , that (I) (we) last saw the deceased alive on Feb. 16, 1967 , and that death occurred at 7 A. M, from causes and on the date stated above.			
22a. SIGNATURE Walter E. Karfman		22b. DATE SIGNED 2/23/67	
22c. PHYSICIAN'S NAME (Type) WALTER E. KARFMAN MD		22d. ADDRESS 4331 Harford Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Feb. 25, 1967	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City or town) (County) (State) Woodlawn, Maryland
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson 4, Maryland		25a. REC'D BY REGISTRAR DATE FEB 28 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			





FOR STATE
HEALTH DEPT.

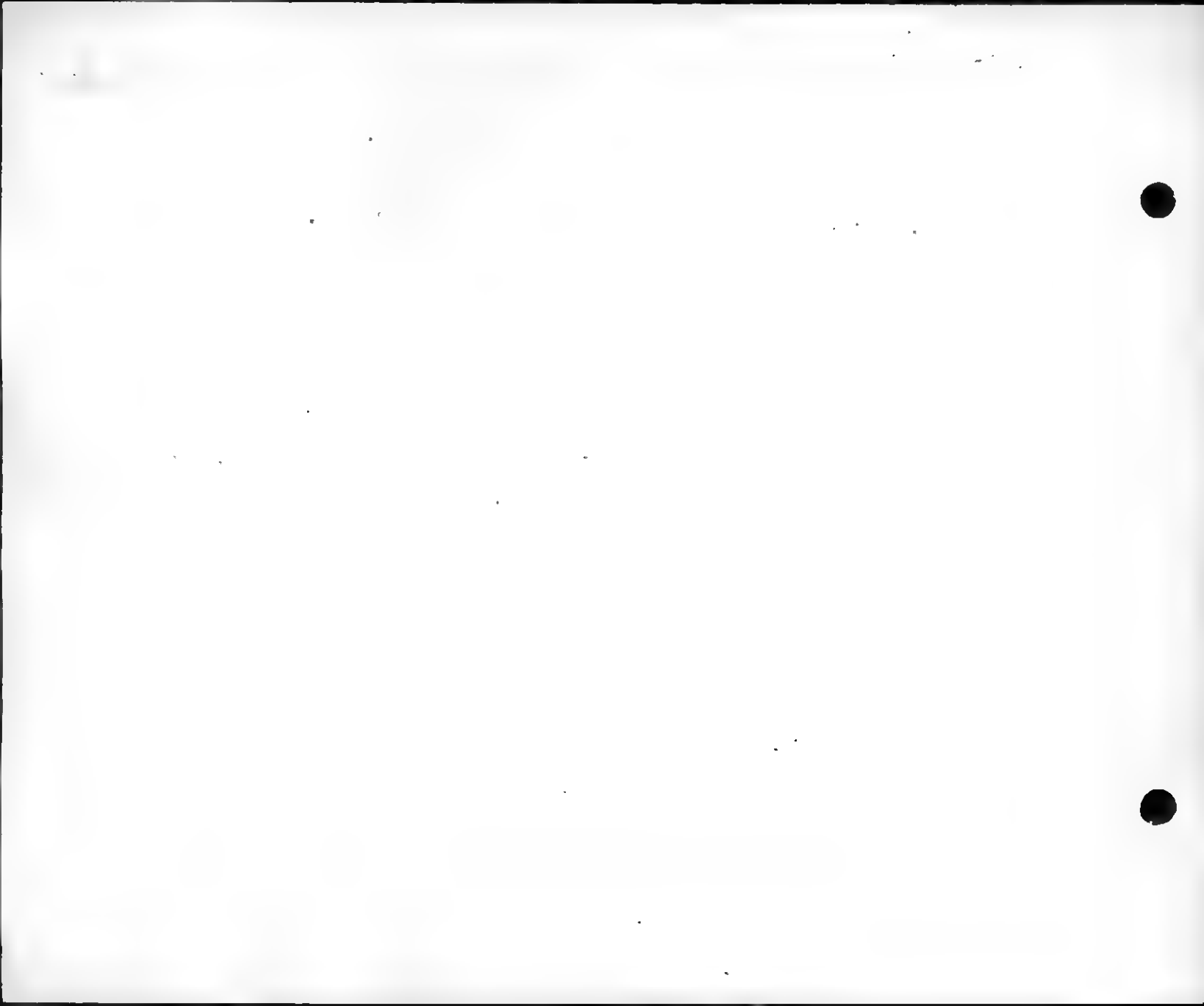
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil on Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01802

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01798

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rowson		c LENGTH OF STAY IN 1b Rowson		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Conn. b COUNTY Greenwich	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			d STREET ADDRESS 772 North St.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Lisa Middle FLINN Last FLINN			4 DATE OF DEATH Month FEB Day 2 Year 1967		
5 SEX F	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH APR. 7 1949	9 AGE (In years last birthday) 17 yrs	IF UNDER 1 YEAR Months 1 Days 17 Hours 17 Min 17
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL GIRL		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) CONN.	
13 FATHER'S NAME GEORGE H FLINN JR			14 MOTHER'S MAIDEN NAME EVELYN LILLEY		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO ---		17 INFORMANT EVELYN FLINN Address ABOVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) IRREVERSIBLE BRAIN DAMAGE 10X DUE TO (b) SUBARACHNOID AND SUBDURAL HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) FELL OFF HORSE			
20c TIME OF INJURY Month, Day, Year Hour AM JAN 30 1967 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		20e PLACE OF INJURY (Home, farm, factory street, office, etc.) SCHOOL	
		20f (City or town) GLENDEN		(County) BALTO. (State) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William A. Pillsbury		M.D.		22. DATE SIGNED 2-2-67	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		CHIEF MED CAL EXAMINER <input type="checkbox"/>		ASS STANT MED CAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Baltimore	
23a BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b DATE THEREOF 2/3/67	23c NAME OF CEMETERY OR CREMATORY PITTSBURG		23d LOCATION (City or Town) (County) (State) PITTSBURG PIT	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS		25a. REC'D BY REGISTRAR DATE 26 1967	
				25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

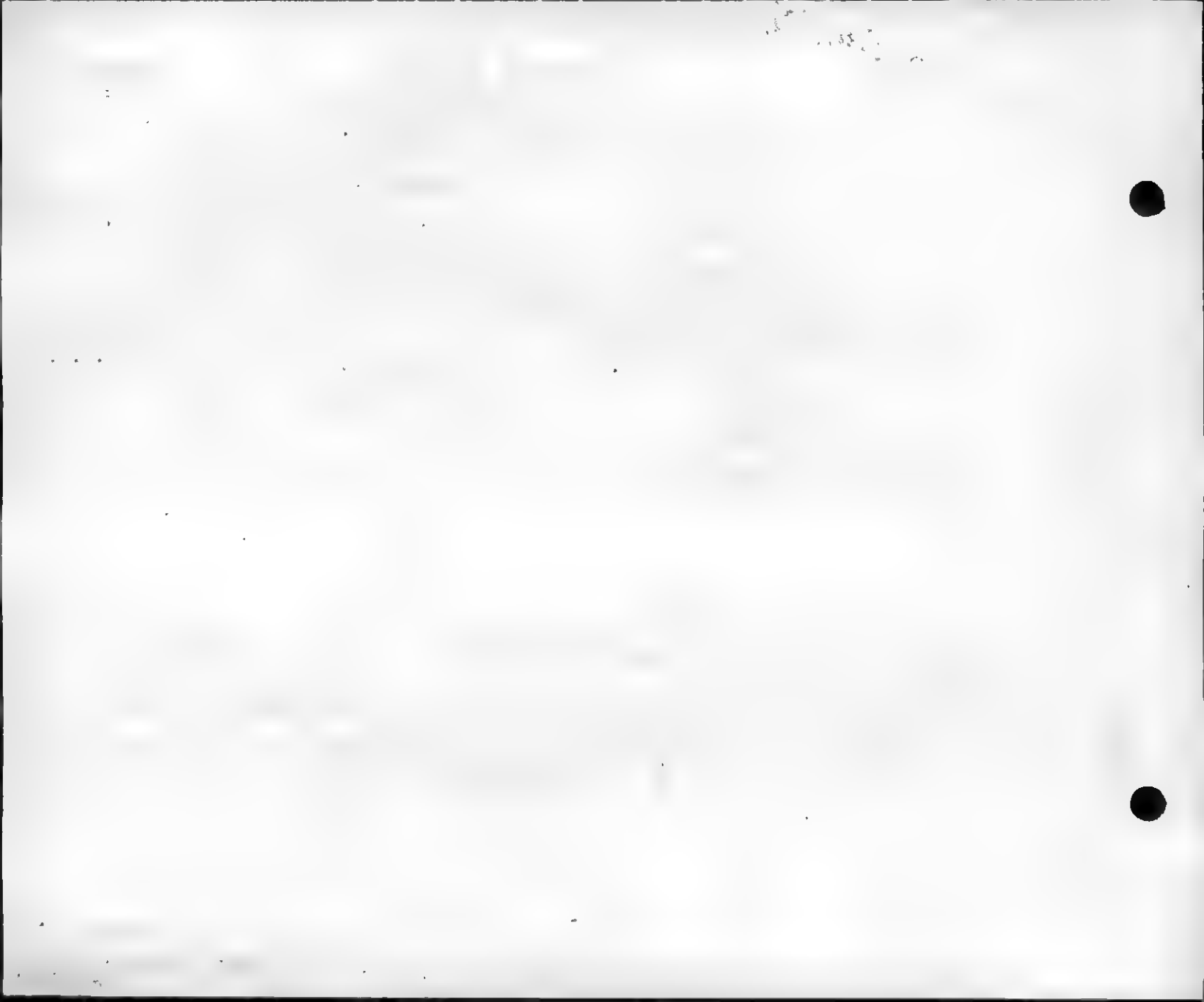
01803

CERTIFICATE OF DEATH

01799

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River			c. LENGTH OF STAY IN 1b Middle River				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ivy Hall Nursing Home				d. STREET ADDRESS Box 455 Burke Road Bowleys Qtrs			
3. NAME OF DECEASED (Type or print) First John Middle Foote Last Foote				4. DATE OF DEATH Month 2 Day 25 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-1895	9. AGE (In years last birthday) 71 yrs	10. IF UNDER 1 YEAR Months 19 Days 67		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			
13. FATHER'S NAME Zachirah Foote				14. MOTHER'S MAIDEN NAME Annie Burkhart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-07-2216		17. INFORMANT Address #4 Mrs Jeanette Fanning 318 Worthington Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure 177X DUE TO Cancer of the esophagus (metastases) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Cancer of the prostate gland (c)					INTERVAL BETWEEN ONSET AND DEATH 6 weeks 9 years		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Suppurative Cardiovascular disease					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 6/15/63 , 1963, to 2/24 , 1967, that (I) (we) lost the deceased alive on 2/24 , 1967, and that death occurred at 2 A M, from causes and on the date stated above.							
22a. SIGNATURE Eugene C. Baumann M.D.				22b. DATE SIGNED 2-27-67			
22c. PHYSICIAN'S NAME (Type) EUGENE C. BAUMANN				22d. ADDRESS 413 EASTERN Ave Baltimore 21.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-28-1967		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Cemetery			
23d. LOCATION (City or town) Bel Air Md.		24. FUNERAL DIRECTOR ADDRESS (36) Lassahn Funeral Home 7401 Belair Road					
25a. REC'D BY REGISTRAR DATE FEE 28 1967				25b. REGISTRAR'S SIGNATURE J. Charles Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

01804

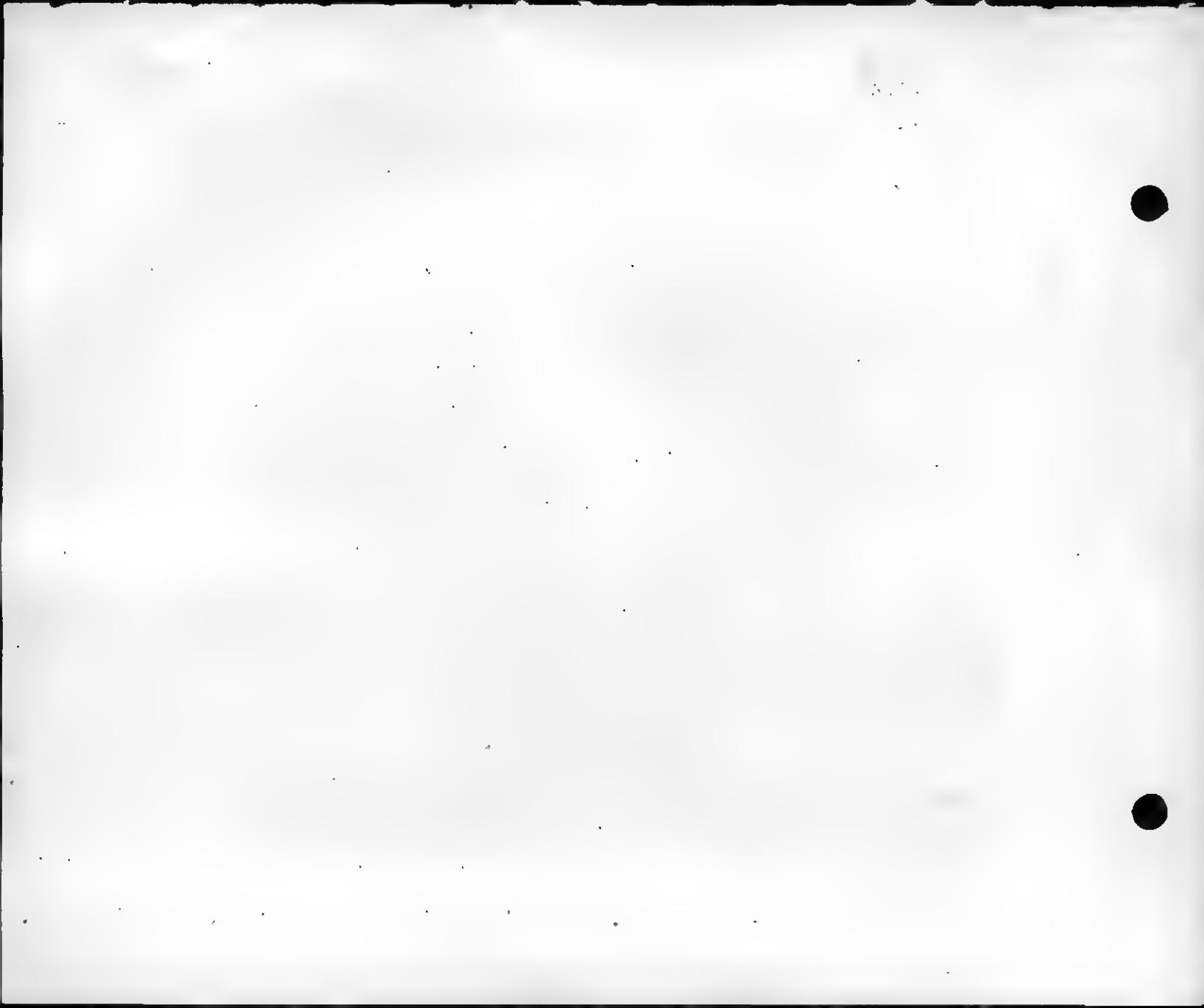
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01800

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(RURAL) BALTIMORE</u> c. LENGTH OF STAY IN 1b <u>52 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MT. VISTA RD.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(RURAL) BALTIMORE</u> d. STREET ADDRESS <u>MT. VISTA RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEONARD MORRIS FORD</u>			4. DATE OF DEATH Month Day Year <u>2 - 8 1967</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>2/19/14</u>		9. AGE (In years last birthday) <u>52 yrs.</u>		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STANDARDS CONTROL</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AIRCRAFT</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>HARFORD CO., MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>BARTLETT FORD</u>			14. MOTHER'S MAIDEN NAME <u>IDA M. SHANE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>259-09-4532</u>		17. INFORMANT Address <u>BALTO CO NO</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> 1712 DUE TO METASTATIC SARCOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <u>12 mos.</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (1) (this hospital) attended the deceased from <u>11/22</u> , 19 <u>67</u> to <u>2/8</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>2/8</u> , 19 <u>67</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Miles E. St. John, MD</u> M.D.			22b. DATE SIGNED <u>2/8/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>MILES E. ST. JOHN, MD.</u>			22d. ADDRESS <u>9660 BELAIR RD. BALTO, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-11-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Ferry Hall, Baltimore Md.</u>							
24. FUNERAL DIRECTOR <u>Lawson Funeral Home 7401 Belair Road 36</u>			25a. REC'D BY REGISTRAR <u>FEB 14 1967</u> 25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

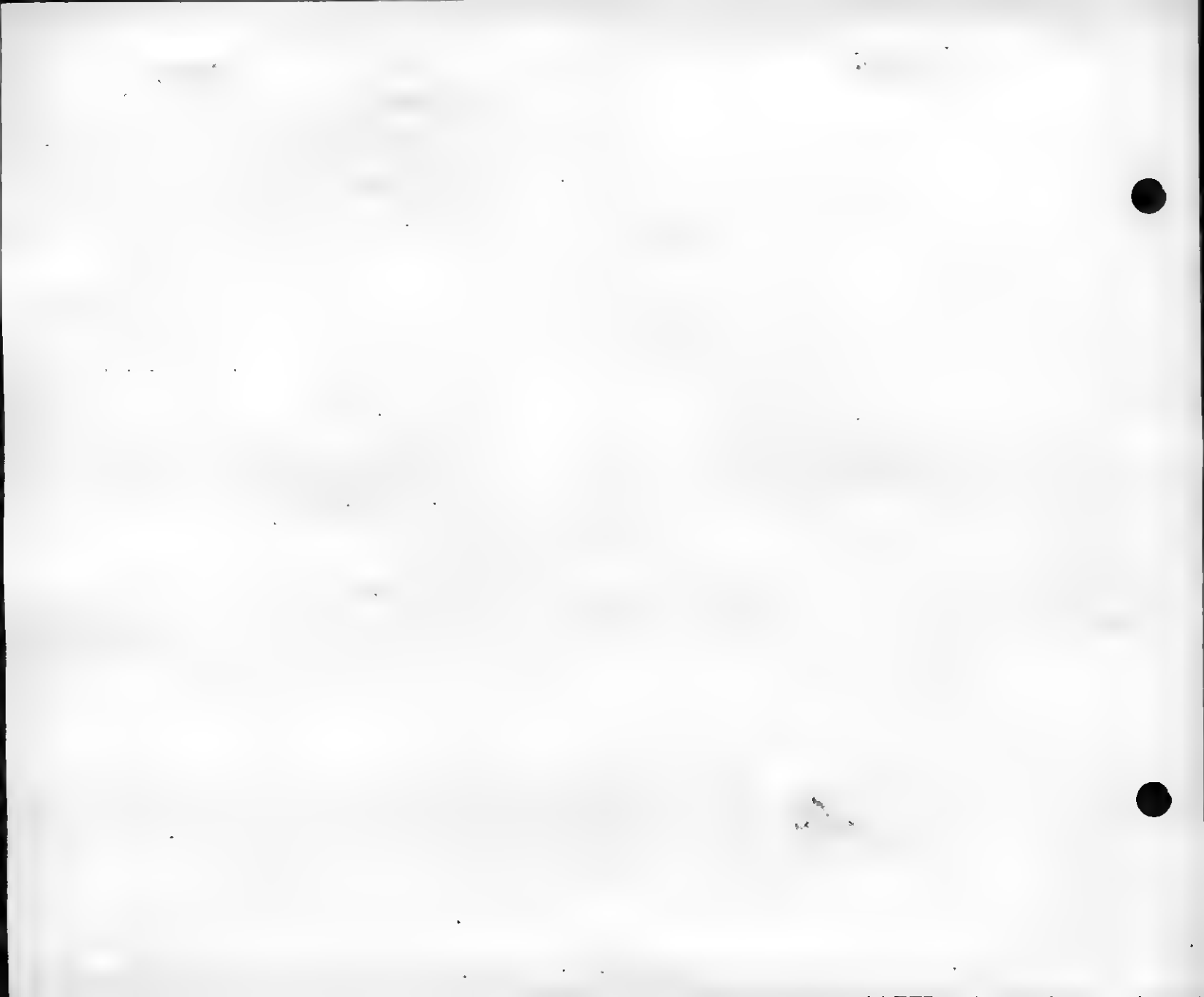
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
item 2 Form 3286 2/24/67 mh

01805

CERTIFICATE OF DEATH

01801

1. PLACE OF DEATH <u>Baltimore</u> a. COUNTY <u>Cockeysville, Towson</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>				c. LENGTH OF STAY IN TB <u>2 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Masonic Homes Cockeysville</u>				e. STREET ADDRESS <u>17 South East Ave.</u> <u>Cockeysville, Maryland</u>			
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>D</u> Last <u>FRANKLIN</u>				4. DATE OF DEATH <u>FEBRUARY 14</u> 19 <u>67</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan, 14, 1887</u>	9. AGE (In years lost birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SILVER SMITH</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>North Attleboro, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John P. Franklin</u>				14. MOTHER'S MAIDEN NAME <u>Laura Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-07-6134</u>		17. INFORMANT Address <u>Masonic Homes Cockeysville, Maryland</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO (b) <u>3. arterio-sclerotic heart disease</u> DUE TO (c) <u>3. Aspiration pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>65</u> , to <u>Feb 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 13</u> , 19 <u>67</u> , and that death occurred at <u>6:50</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>James H. Hamed M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>FEB 14, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HAMED</u>		22d. ADDRESS <u>MASONIC HOMES</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Elkridge, Maryland</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u>				25a. REC'D. BY REGISTRAR <u>37</u>		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01806

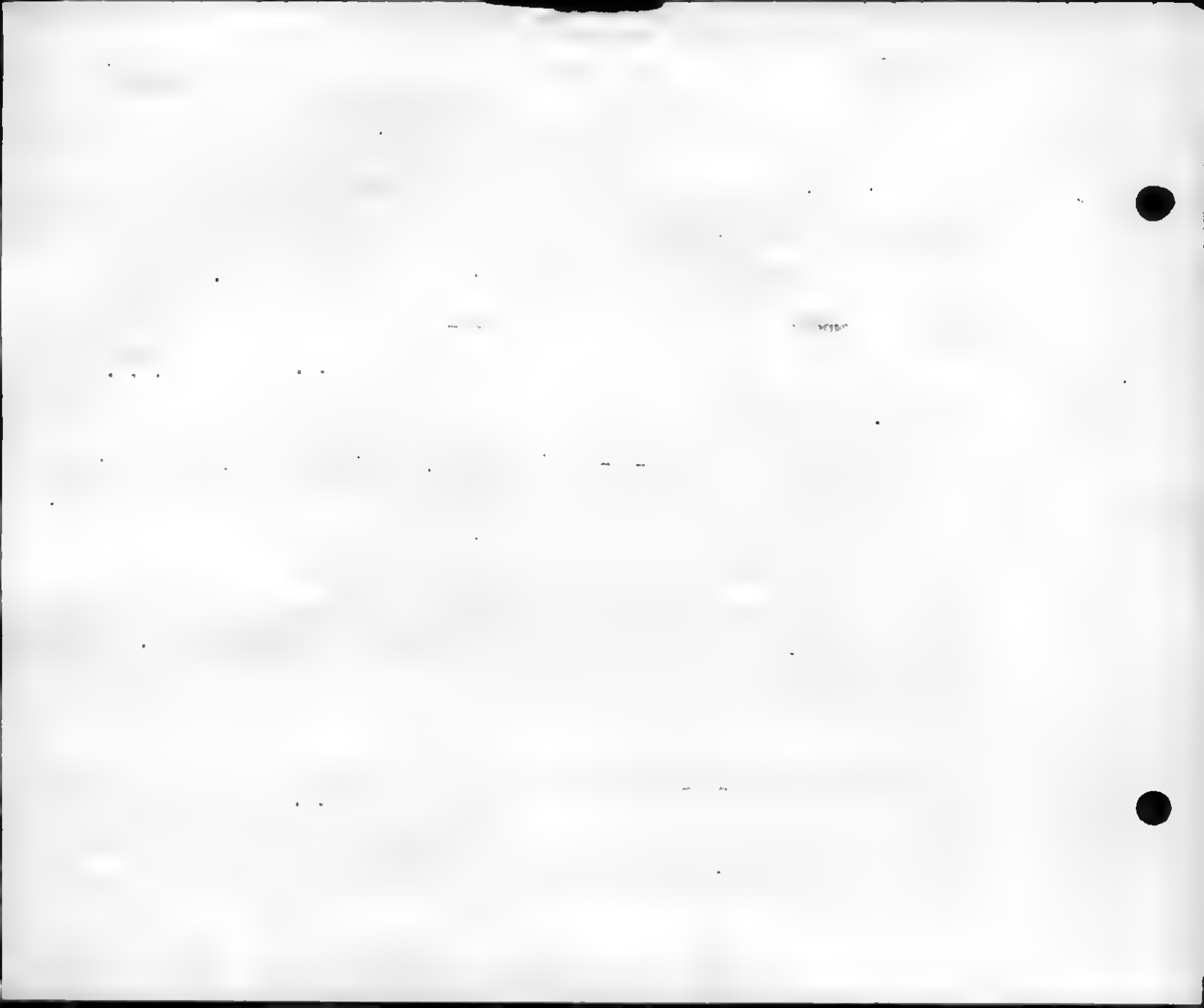
CERTIFICATE OF DEATH

01802

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 31yr29dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Lee		4. DATE OF DEATH Month Feb. Day 23 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-88
9. AGE (In years past-birthday) yrs 78		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Richardson		14. MOTHER'S MAIDEN NAME Virginia Grinder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 219-54-3115T	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute bilateral pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pulmonary disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chronic brain syndrome associated with cerebral arterio.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-24-36 , 19__, to 2-23 , 19 67 , that (I) (we) last saw the deceased alive on 2-23-67 , 19__, and that death occurred at 6:50 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Evelio A. Felipe</i>		22b. DATE SIGNED 2-24-67	
22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe		22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3-1-67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Old Frederick Road Baltimore
24. FUNERAL DIRECTOR Krause Funeral Home 12165 Charles St		25a. REC'D BY REGISTRAR DATE MAR 7 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

01807

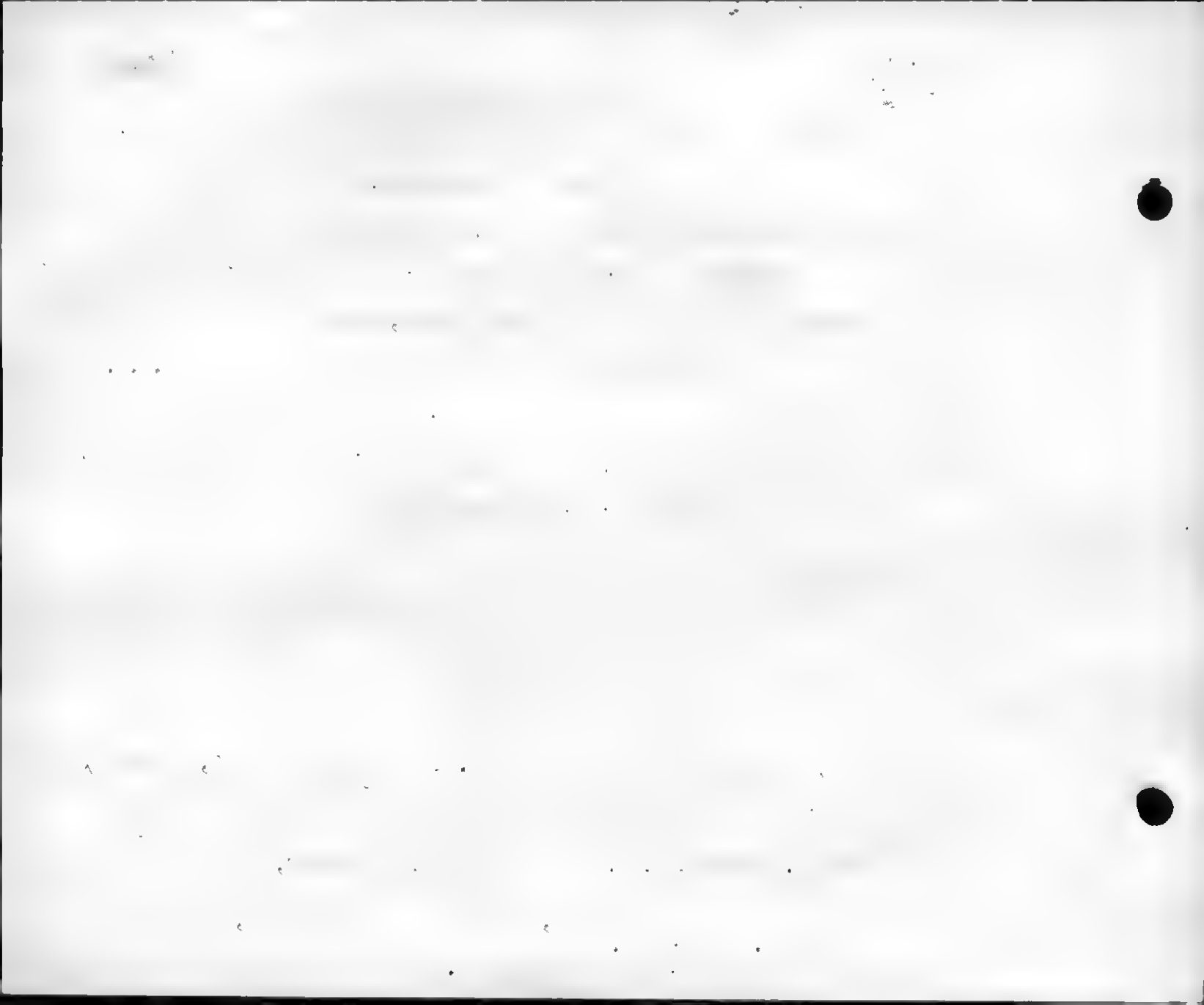
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01803

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c LENGTH OF STAY IN 1b 50 DAYS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d STREET ADDRESS 739 HOWARD ROAD		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First CHARLES Middle JOSEPH Last FREEMAN				4 DATE OF DEATH Month FEBRUARY Day 2 Year 19 67			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH FEBRUARY 6, 1900		9 AGE (In years last birthday) yrs 66	10 UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b KIND OF BUSINESS OR INDUSTRY AUTOMOBILE		11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME SAMUEL BROWN FREEMAN				14 MOTHER'S MAIDEN NAME MARY ELIZABETH KIRWIN			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16 SOCIAL SECURITY NO. 212 01 77 80		17 INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS OF LIVER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from DEC. 11, 19 66 to FEB 2, 19 67 that (2) (we) last saw the deceased alive on FEB 2 19 67 , and that death occurred at 1110 PM , from causes and on the date stated above.							
22a. SIGNATURE J. D. Talbert				22b. DATE SIGNED 2/3/67		22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.	
22d. ADDRESS VAH FORT HOWARD, MARYLAND							
23a BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF Feb. 6, 1967		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE, NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24 FUNERAL DIRECTOR FRANK H. NEWELL INC.				25a. REC'D BY REGISTRAR DATE FEB 6 1967		25b. REGISTRAR'S SIGNATURE Charles Jones	
REISTERSTOWN RD & WALDRON AVE, PIKESVILLE, MD.							

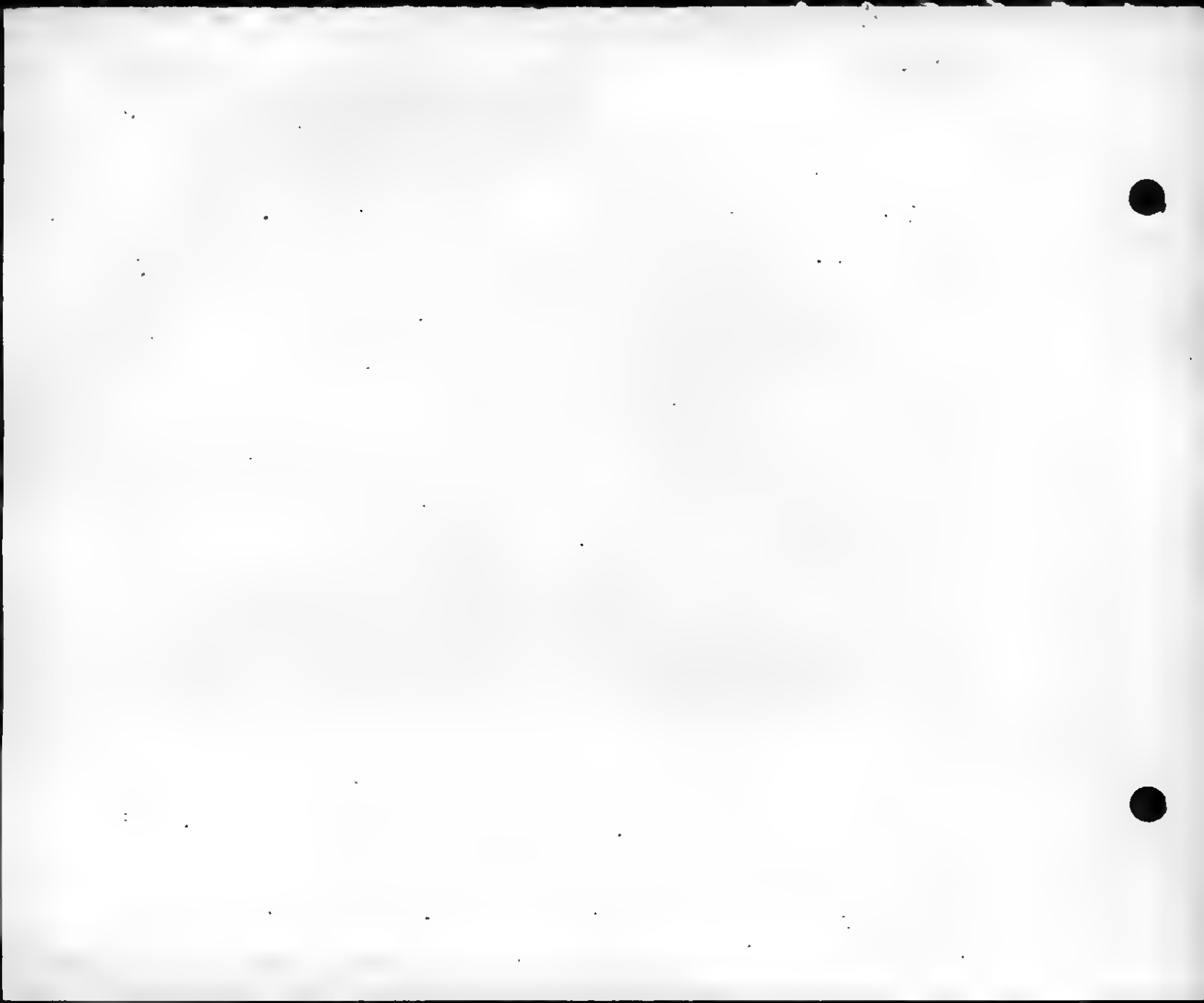


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01808 CERTIFICATE OF DEATH 01804

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SPARKS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SPARKS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPARKS ROAD		d. STREET ADDRESS SPARKS ROAD	
3. NAME OF DECEASED (Type or print) FREDERICK D. FRUTCHER		4. DATE OF DEATH FEB. 25 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 26, 1907
9a. AGE (in years last birthday) 59 yrs.		9b. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOK-KEEPER		10b. KIND OF BUSINESS OR INDUSTRY WOLF & MANN CO.	
11. BIRTHPLACE (County & State, or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MARQUIS P. FRUTCHER		14. MOTHER'S MAIDEN NAME MARIE DOUBMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 143-01-4921	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Removal of Esophageal Varices DUE TO (b) Cirrhosis of Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 yr 6-10 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-24 , 19 67 , to 2-25 , 19 67 , that (I) (we) last saw the deceased alive on 2-25 , 19 67 , and that death occurred at 9 A.M. from the causes and on the date stated above.			
22a. SIGNATURE C. Herbert Mueller Jr.		22b. DATE SIGNED 2-25-67	
22c. PHYSICIAN'S NAME (Type) C. HERBERT MUELLER JR.		22d. ADDRESS PARKTON MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF FEB. 27, 1967	23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEM.	23d. LOCATION (City, town or county) (State) BALTIMORE, MD.
24. FUNERAL DIRECTOR John Burns Son's		25a. REC'D BY REGISTRAR John Burns	
25b. REGISTRAR'S SIGNATURE John Burns		DATE MAR 2 1967	



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

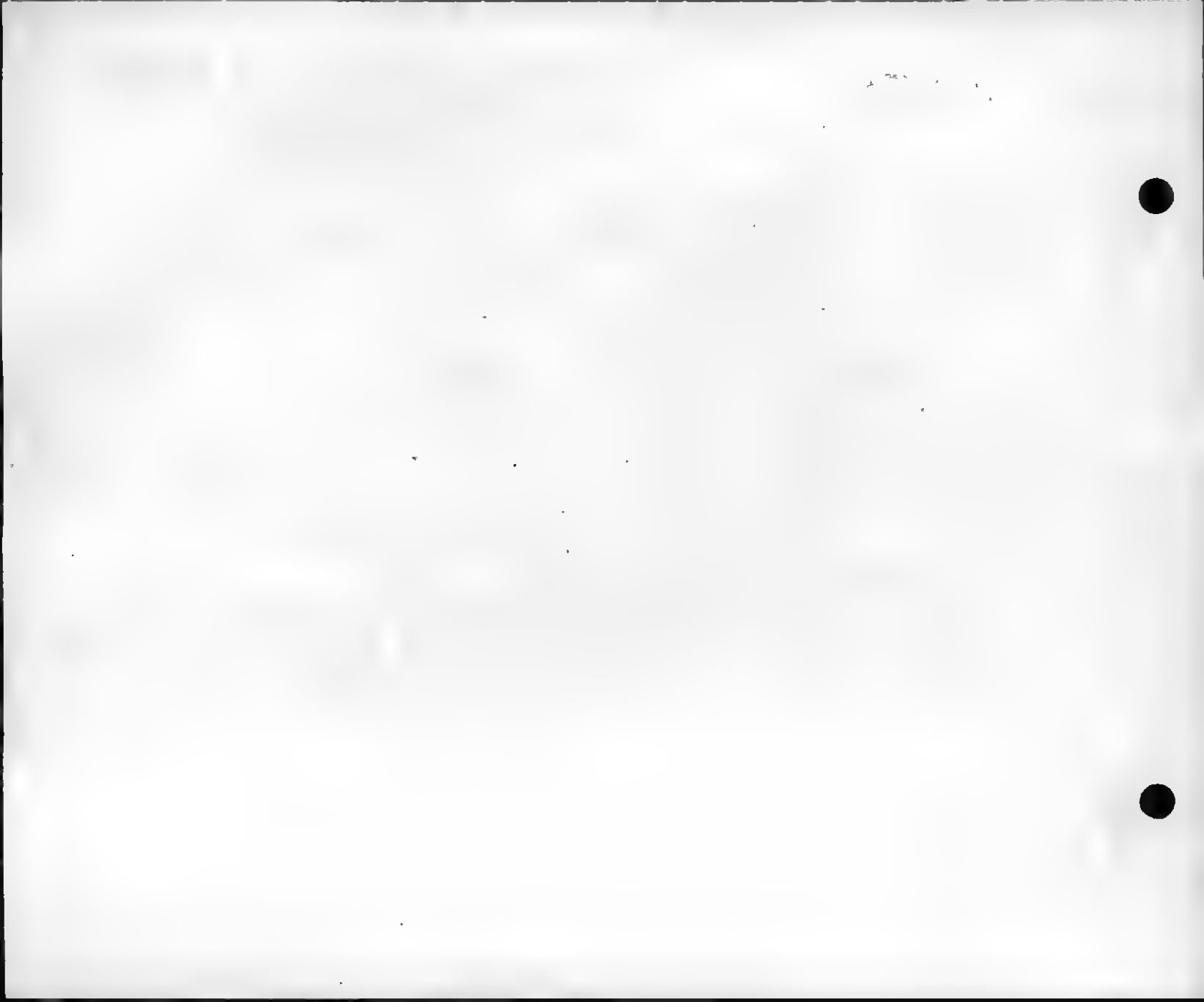
01805

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write R.R. No. and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b Woodlawn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle M. Last Fuller		4. DATE OF DEATH Month Feb. Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-97
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tile (Retired)		11b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Fuller	
14. MOTHER'S MAIDEN NAME Genevieve Maisel		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW I	
16. SOCIAL SECURITY NO 714-05-6755A		17. INFORMANT Thos. Fuller-6725 Kincheloe Ave., Woodlawn, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive retroperitoneal hemorrhage DUE TO (b) Ruptured aortic aneurysm - Thoracic DUE TO (c) 3 hrs.		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		22. DATE SIGNED 2-27-67	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		6 Hanover Rd. Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/1/67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard		4107 Wilkens Ave.	
25a. REC'D BY REGISTRAR MAR 3 1967		25b. REGISTRAR'S SIGNATURE J. Charles J. J. J.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

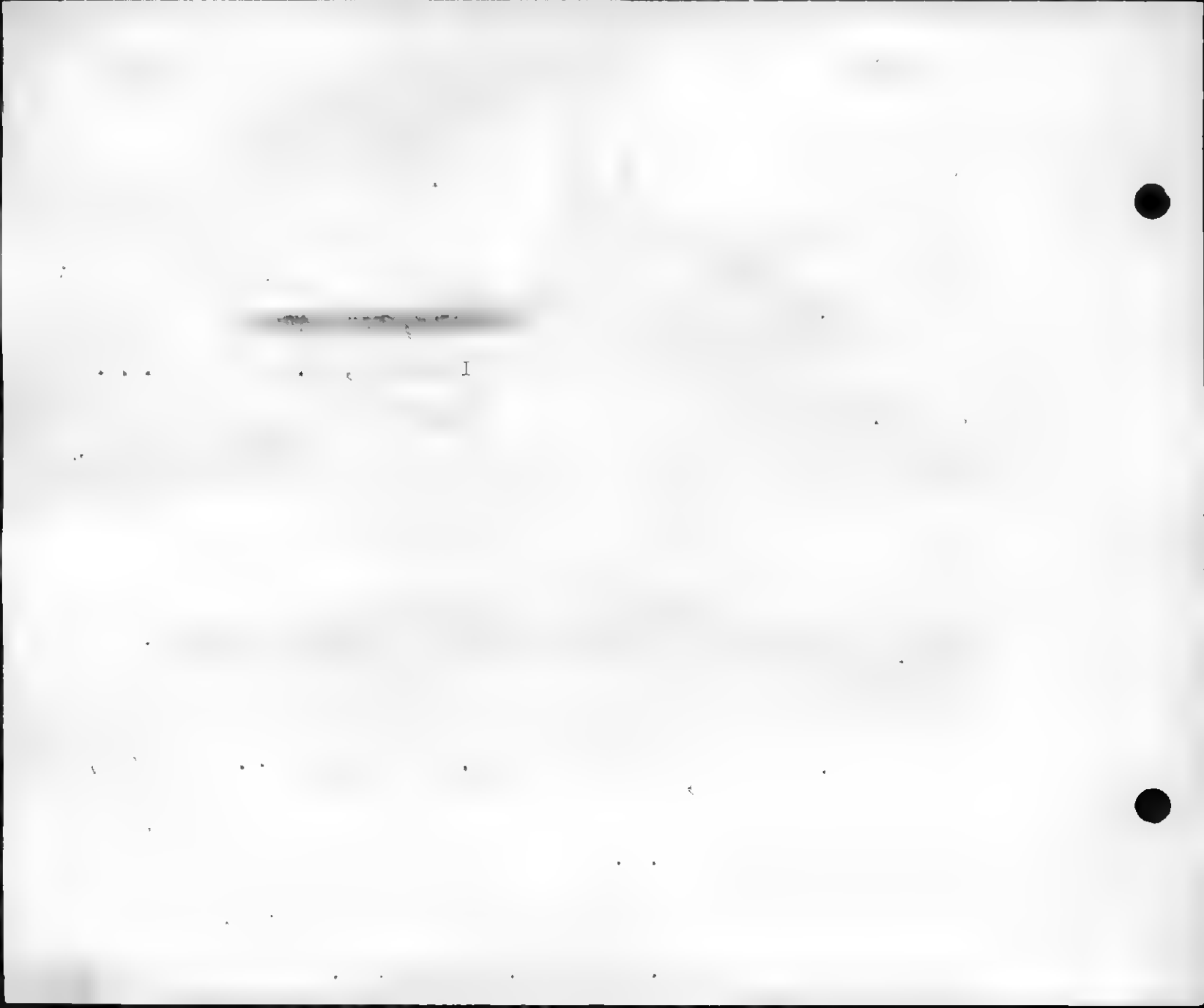
Division of STATISTICAL RECORDS AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01810

CERTIFICATE OF DEATH

01806

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY -	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c LENGTH OF STAY IN 1b 60 DAYS	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d STREET ADDRESS 1380 NORTH CALHOUN STREET	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First CHARLES Middle WILLIAM Last HENDERSON GASKINS		4 DATE OF DEATH Month FEBRUARY Day 6 Year 1967	
5 SEX MALE	6 COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) August 5, 1909 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11 BIRTHPLACE (County & State, or foreign country) LOTESBURG, VA.	
13 FATHER'S NAME JOSEPH GASKINS		14. MOTHER'S MAIDEN NAME LITZA KING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO 215 46 89 12	
17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INFARCTION OF MYOCARDIUM, ACUTE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CORONARY THROMBOSIS, ACUTE (c) ARTERIOSCLEROTIC HEART DISEASE			INTERVA. BETWEEN ONSET AND DEATH
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NEOPLASM METASTATIC, HEAD & NECK OF LEFT FEMUR, PRIMARY SITE UNKNOWN. COIT. PYELONEPHRITIS, CHRONIC			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (X) (this hospital) attended the deceased from DEC. 8 , 19 66 , to FEB. 6 , 19 67 , that (X) (we) last saw the deceased alive on FEB 6 , 19 67 , and that death occurred at 1110A , from causes and on the date stated above.		21f. (City or town) (County) (State)	
22a. SIGNATURE George Dudas, MD		22b. DATE SIGNED 2/7/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2-13-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR Kelson		25a. REC'D BY REGISTRAR 1967	
25b. REGISTRAR'S SIGNATURE Kelson			

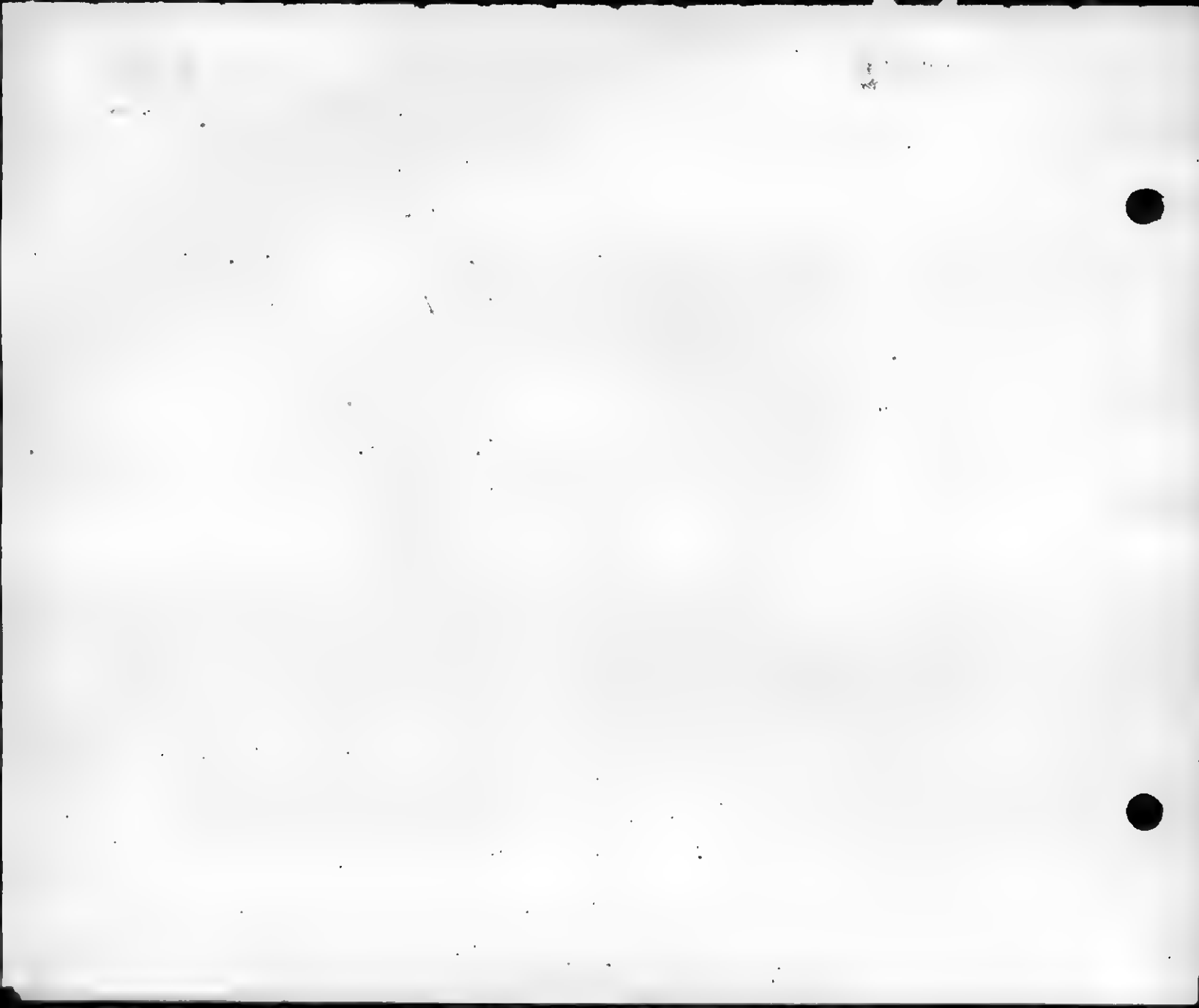


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01811					01807				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Baltimore					a. STATE Maryland b. COUNTY CARROLL Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminister				
c. LENGTH OF STAY IN 1d 2 WEEKS					d. STREET ADDRESS 18 Webster Street				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shady Nook Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year
Ada Rebecca Gaver						Feb. 11			19 67
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours Min.
F	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10/30/1886	80 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) FREDERICK, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tyson D. Dubel					14. MOTHER'S MAIDEN NAME Amanda C.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
no				Mrs. Glayds S. Latimer			Ellicott City, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 2 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19		While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 1-23 , 19 67 , to 2-11 , 19 67 , that (I) (we) last saw the deceased alive on 2-10 , 19 67 , and that death occurred at 10 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Thomas F. Herbert, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-11-67			
22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.				22d. ADDRESS 44 Church Rd Ellicott City, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL		2/14/67		ST. PAUL'S LUTH. CEMETERY		MYERSVILLE, MD.			
24. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md.				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						DATE FEB 15 1967		Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

01812

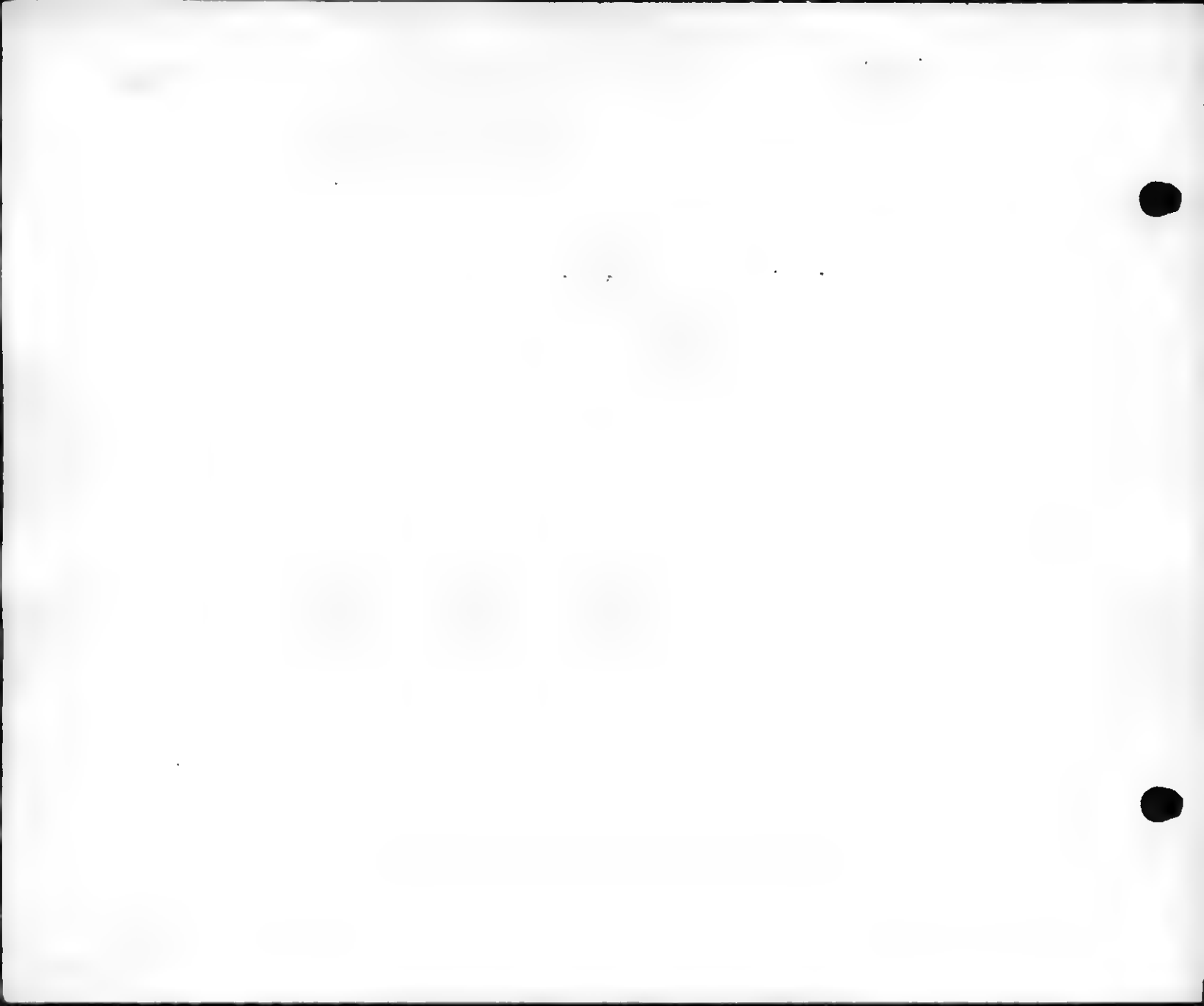
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01808

1 PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>City.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Int. Wilson, Md.</u>		c. LENGTH OF STAY IN ^b <u>3.5 mn.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Int. Wilson State Hosp.</u>		d. STREET ADDRESS <u>2001 Hargrove St.</u>	
3 NAME OF DECEASED (Type or print) <u>CLARENCE SAVAGE GIBSON</u>		4 DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-14-'14</u>
9 AGE (In years last birthday) <u>52</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>laborer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>fruit market (union) Ind.</u>	
11 BIRTHPLACE (State or foreign country) <u>(union) Ind.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>	
13 FATHER'S NAME <u>Howard Gibson</u>		14. MOTHER'S MAIDEN NAME <u>Missouri Savage</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>		16 SOCIAL SECURITY NO. <u>216-09-3106</u>	
17 INFORMANT Address <u>Int. Wilson Records - Int. Wilson, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cor-Pulmonary</u> <u>vol. i</u> DUE TO (b) <u>for Advanced Pulmonary Tbc.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mts.</u> <u>4 1/2 yrs.</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None.</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <u>None.</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year hour a.m. <u>none</u> 19 p.m. <u> </u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <u>none</u>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u>none</u>	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u> M.D.		22. DATE SIGNED <u>2-19-67</u>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>2-23-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	23d LOCATION (City or town) (County) (State) <u>BALTO. Md.</u>
24 FUNERAL DIRECTOR <u>GEO. NELSON FUNERAL HOME 1348 CALHOUN ST.</u>		25a REC'D BY REGISTRAR DATE <u>2-21-1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

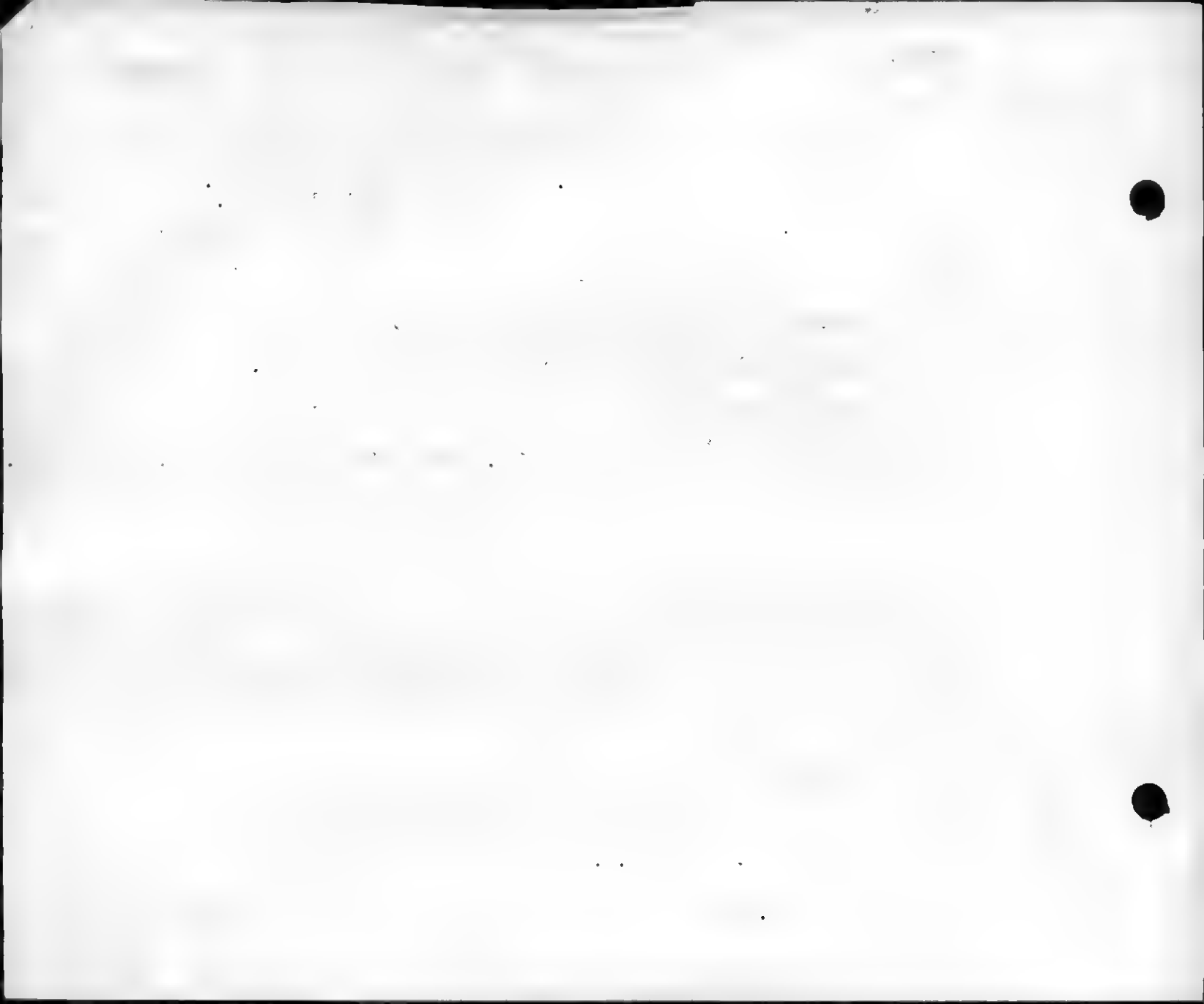
01813

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01809

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown			c. LENGTH OF STAY in 1b 1 hr.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore Co. General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Harlan Middle Drake Last Gilkerson			4 DATE OF DEATH Month 2 Day 18 Year 1967		
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH April 4, 1933		9 AGE (in years last birthday) 33 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitation truck		10b. KIND OF BUSINESS OR INDUSTRY Arthur Mosher	11 BIRTHPLACE (State or foreign country) Prichard, West Va.		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Burgess Gilkerson			14. MOTHER'S MAIDEN NAME Virginia Perry		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16 SOCIAL SECURITY NO 706-18-6427	17 INFORMANT Mrs. Agnes Wright, 124 Slade Ave., Pikesville.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning 241.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute alcoholic intoxication					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Inhalation of exhaust fumes from auto			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2 p.m. 18 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Driveway		20f. City or town (County) (State) Baltimore Md
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2/19/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 22, 1967	23c. NAME OF CEMETERY OR CREMATORY Gilkerson Cemetery		23d. LOCATION (City or town) (County) (State) Prichard, West Virginia
24. FUNERAL DIRECTOR Frank H. Newell, Pikesville 8, Md.		ADDRESS Pikesville 8, Md.		25a. REC'D BY REGISTRAR DA FEB 27 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01814

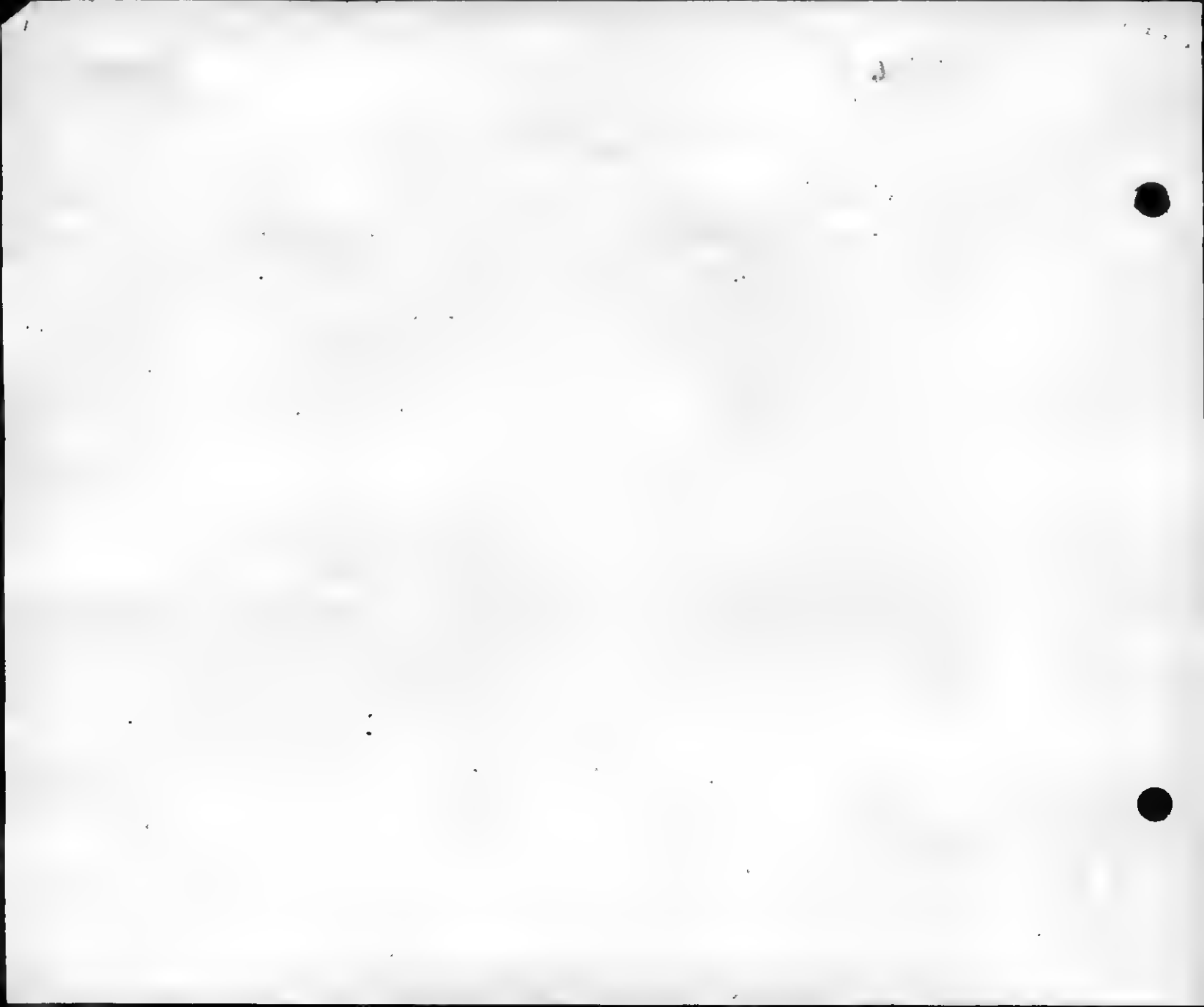
CERTIFICATE OF DEATH

01810

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c LENGTH OF STAY IN 1b Life	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d STREET ADDRESS 2645 Wendover Rd.	
3. NAME OF DECEASED (Type or print) Baby boy		4 DATE OF DEATH February 5, 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 5, 1967
9 AGE (In years, lost birthday) 17		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) BALTO. Md.	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Paul Francis Goedeke	
14 MOTHER'S MAIDEN NAME French, Mrs. Joan Angela		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO.		17. INFORMANT Parents Address same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176X Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 5, 1967 to Feb. 5, 1967 , that (I) (we) last saw the deceased alive on Feb. 5, 1967 , and that death occurred at 7:55 AM , from causes and on the date stated above.			
22a. SIGNATURE Jose A. Aguto M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED Feb. 5 1967
22c. PHYSICIAN'S NAME (Type) Jose A. Aguto		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 2-8-67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d. LOCATION (City or town) (County) (State) BALTO Md
24. FUNERAL DIRECTOR CHAR F. EVANS		25a. REC'D BY REGISTRAR FEB 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

01815

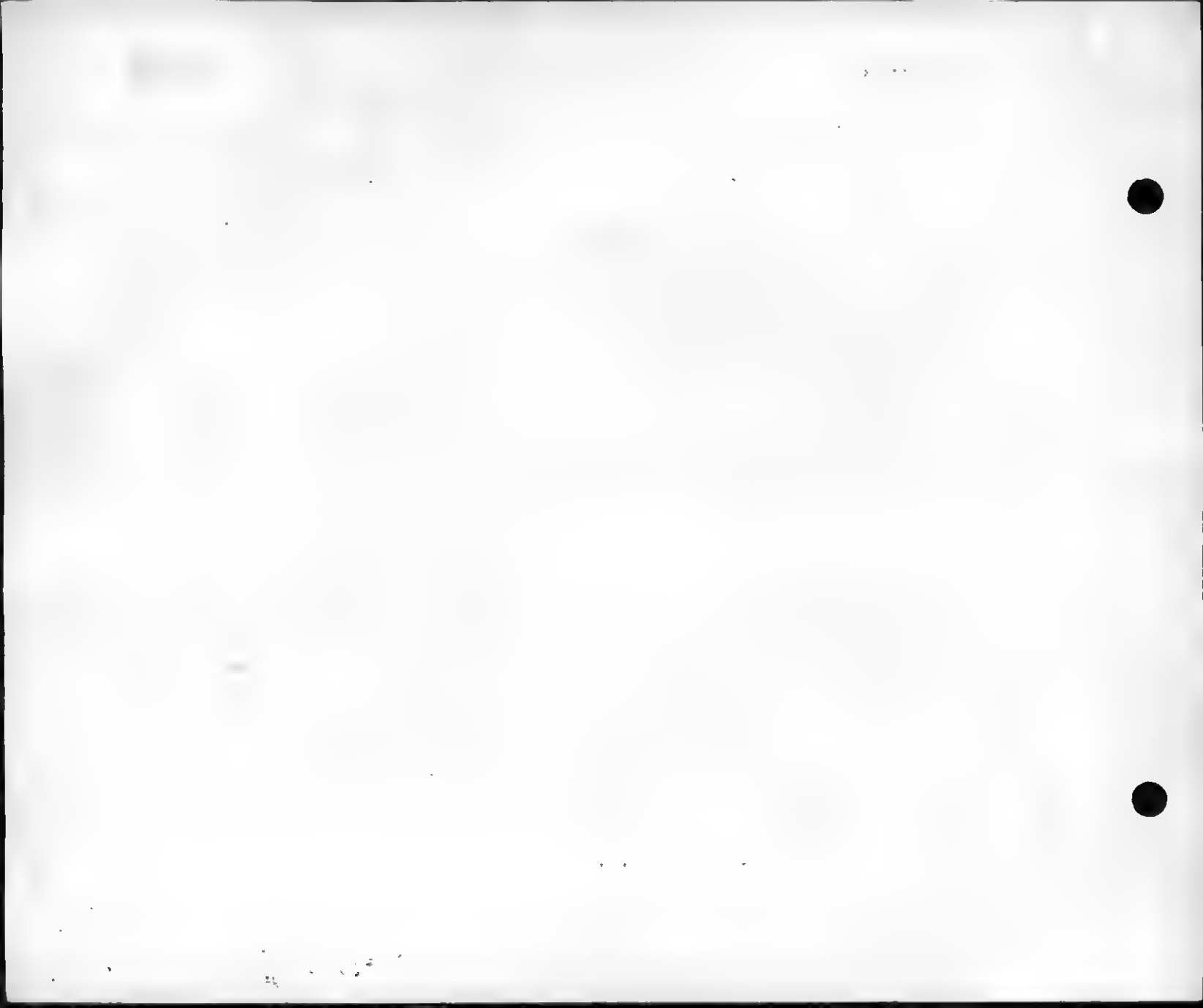
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01811

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Hyattsville			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville-rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove Hospital				e. STREET ADDRESS 7952 Riggs Rd.			
3. NAME OF DECEASED (Type or print) First Betty Middle C. Last Golden				4. DATE OF DEATH Month 2 Day 17 Year 67			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 10, 1903	9. AGE (In years last birthday) 63 yrs	IF UNDER 1 YEAR Months 6 Days 17	IF UNDER 24 HRS Hours 19 Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA		
12. CITIZEN OF WHAT COUNTRY? U-S A.			13. FATHER'S NAME SAMUEL				
14. MOTHER'S MAIDEN NAME IDA LERNER			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				
16. SOCIAL SECURITY NO. V15-09-1253			17. INFORMANT STANLEY GOLDEN				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Death during epileptic seizure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (c) Due to			INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF N.L.R. Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22. DATE SIGNED 2/18/67			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
Address (Street, city, town or county)			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				
23b. DATE THEREOF 2/19/67			23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION (City or Town) (County) (State) Hyattsville, Mont. Md.		
24. FUNERAL DIRECTOR SYLVAN S. LEWIS + SON			ADDRESS GARRISON, MD.		25a. REC'D BY REGISTRAR FEB 21 1967		
25b. REGISTRAR'S SIGNATURE Charles Judge							

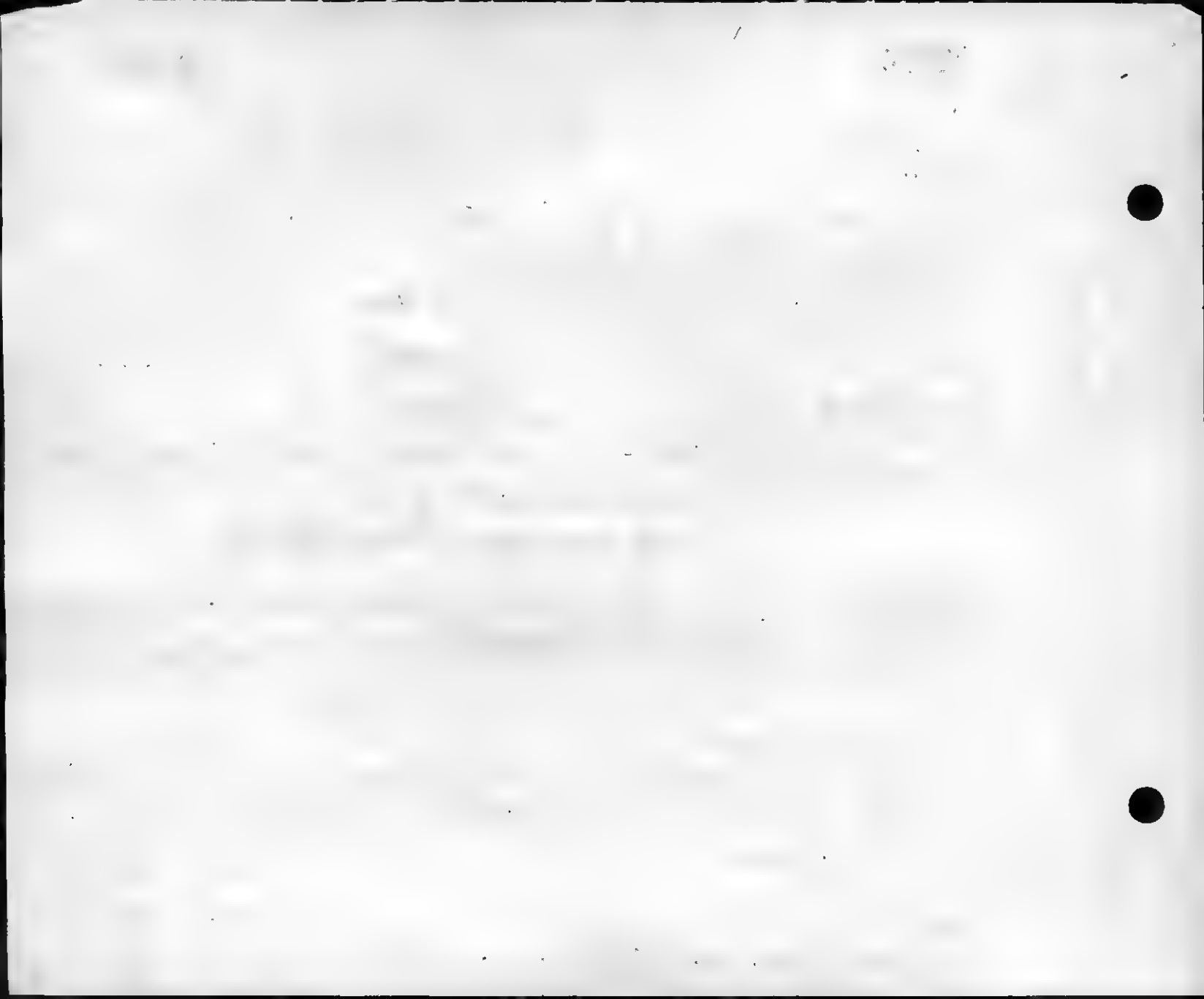
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01816					01812				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)				
a. COUNTY Baltimore			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b MARYLAND			d. STREET ADDRESS 5709 Winner Ave. 21215	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dulaney-Towson Nursing Home, 111 West Rd. Towson, Md.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM GOODMAN			4. DATE OF DEATH Month 2 Day 26 Year 1967						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/8/87		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail			10b. KIND OF BUSINESS OR INDUSTRY Merchant			11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Goodman					14. MOTHER'S MAIDEN NAME Rebecca ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 219-32-1879		17. INFORMANT Address Mrs. Rebecca Goodman, 5709 Winner Avenue				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA + DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thromboses								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 2/26 , 19 67 , to 2/26 , 19 67 , that (I) (we) last saw the deceased alive on 2/26 , 19 67 , and that death occurred at 4:20 PM , from the causes and on the date stated above.									
22a. SIGNATURE Leonard H. Golombek					22b. DATE SIGNED 2/26/67		22c. PHYSICIAN'S NAME (Type) LEONARD H. GOLOMBEK		
22d. ADDRESS Liberty Road									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/28/67		23c. NAME OF CEMETERY OR CREMATORY Beth Jacob		23d. LOCATION (City, town or county) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.					25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01817

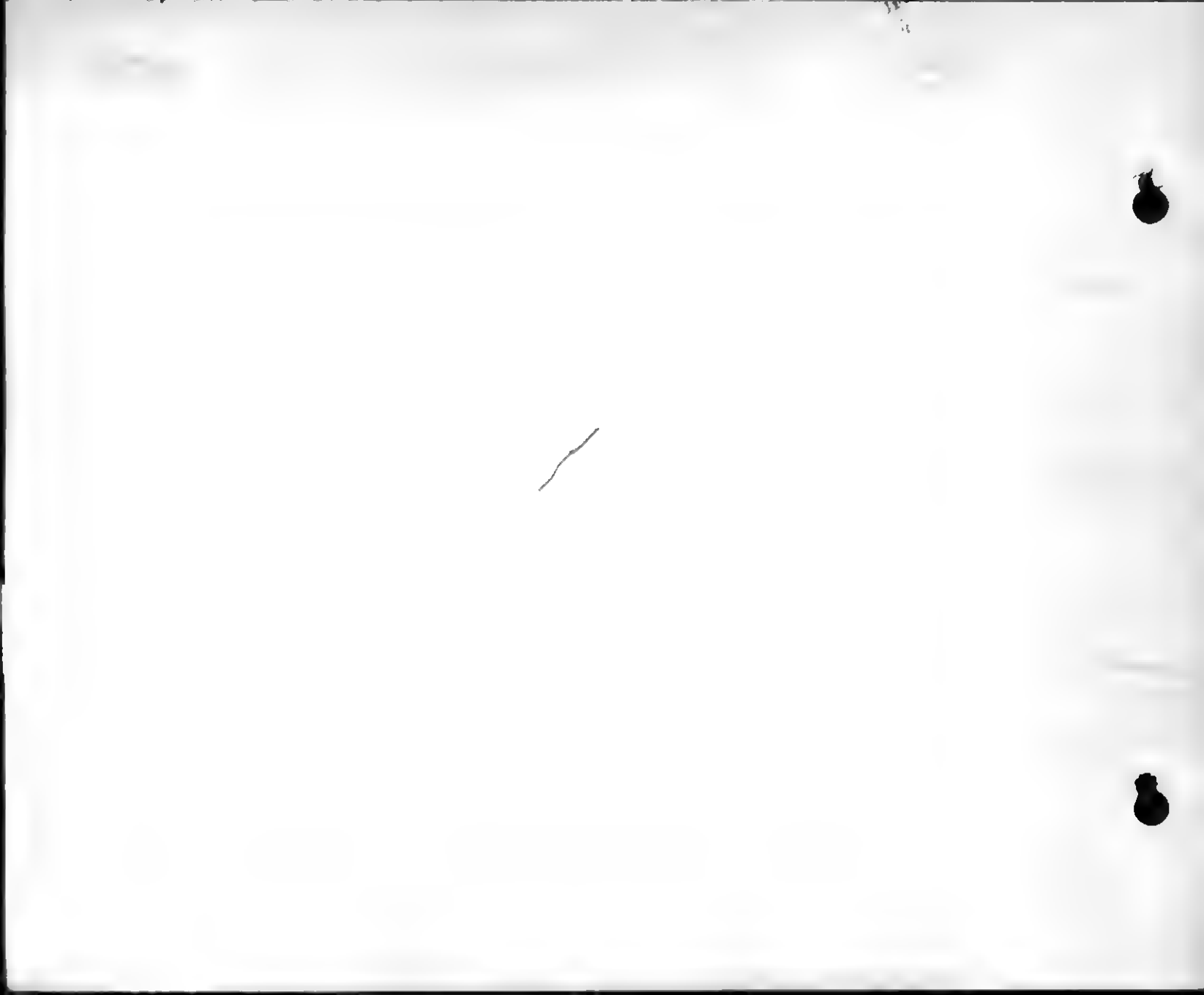
CERTIFICATE OF DEATH

03212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 77 hours after death.

1. NAME OF DECEASED (Type or Print) MRY C. GORMAN		2. DATE AND HOUR OF DEATH FEB. 23, 1967 9:10 A.M.	
3. PLACE OF DEATH (Where deceased died. If institution, residence before admission) BALTIMORE COUNTY		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) MARYLAND APTS. 3501 ST. PAUL S.	
FULL NAME OF HOSPITAL OR INSTITUTION ARMACOST NURSING HOME 312 REGESTER AVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 5/23/35
9. AGE (In years last birthday) 31		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN J. GORMAN		14. MOTHER'S MAIDEN NAME JANE DALLY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 1-1-1-1-1-1-1-1-1-1	
17. INFORMANT MR. T. J. JROGAN, JR		ADDRESS 929 N. HOWARD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cancer of Breast		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stated the UNDERLYING CONDITION last. (APPROX.) While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Feb 9 1967 to Feb 28 1967 that (I) (we) last saw the deceased alive on Feb 27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE W. J. Helmer		23B. DATE SIGNED 3-1-67	
23C. PHYSICIAN'S NAME (Type) DR. WILLIAM G. HELMER		23D. ADDRESS 5006 Roland Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/2/67	
24C. NAME of CEMETERY or CREMATORY NEW CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967		25B. NAME OF REGISTRAR Charles Judge	
25C. FUNERAL DIRECTOR F.W. MEARS & SON		ADDRESS 305 N. CALVERT S	



1
FOR STATE
HEALTH DEPT.

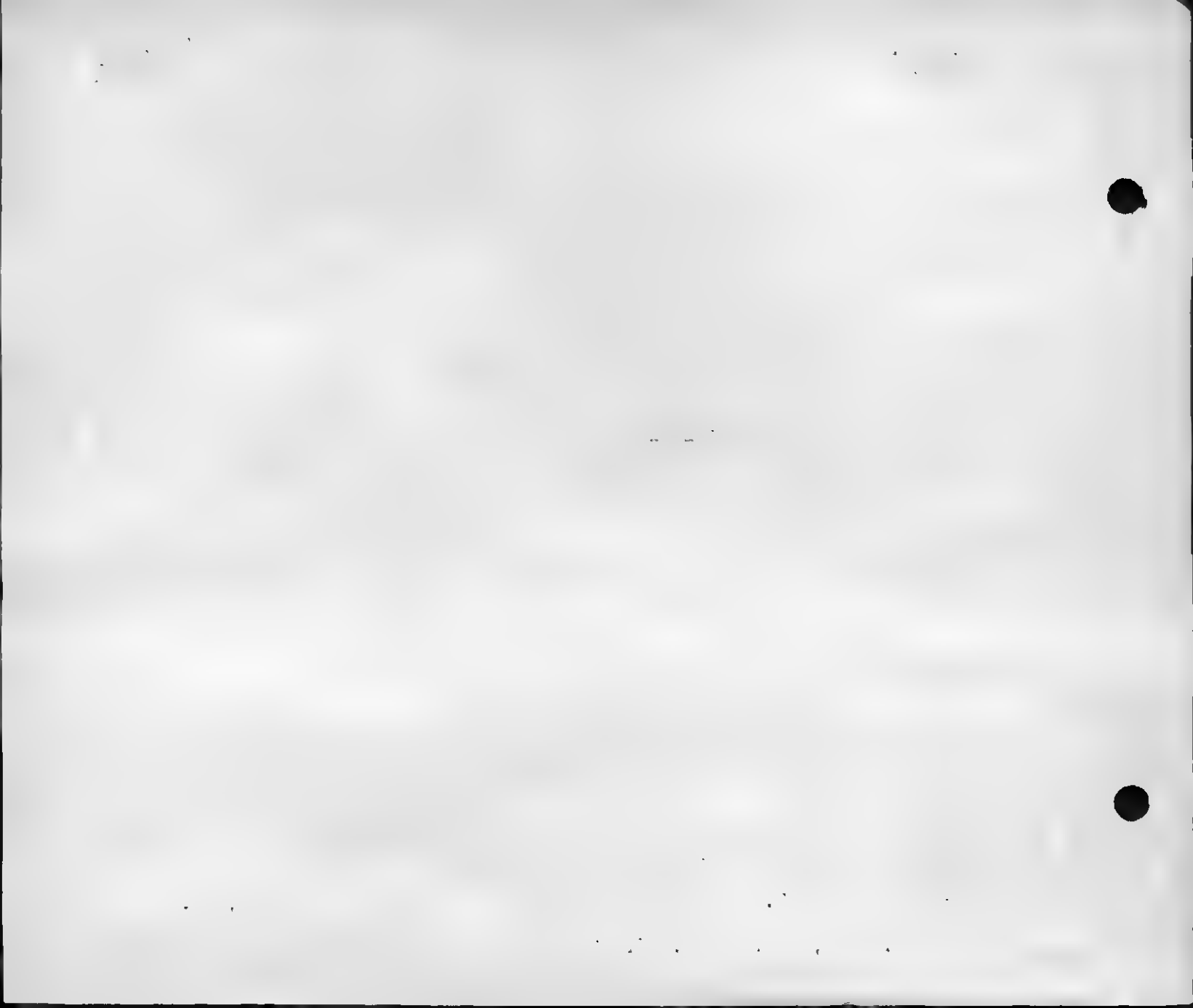
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

<div> <div> <div>1</div> <div>01818</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>01813</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN <u>Baltimore</u> (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>843 Greenway</u>				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>8432 Greenway Rd Apt D</u>							
3. NAME OF DECEASED (Type or print) <u>CLARENCE FREDERICK GRAESER</u> First Middle Last 4. DATE OF DEATH <u>Feb 8 1967</u> Month Day Year 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 24 1897</u> Month Day Year 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Insurance Rep</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance Ind</u> 11. BIRTHPLACE (State or foreign country) <u>Ind</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Graeser</u> 14. MOTHER'S MAIDEN NAME <u>Margaret Mack</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>212-09-2363A</u> 17. INFORMANT <u>George Howard Wilmot</u> Address <u>2669 Cate Rd</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Q. @ V.D.</u> (b) <u>(arteriosclerotic Cardiovasc Dis)</u> DUE TO <u>(a), stating the underlying cause last.</u> (c) <u>Non Remund Ca</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bowel - 7 yrs post op Colostomy</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <u>3:00</u> p.m. 19 <u>67</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> F.T. KASIK JR MD Address (Street, city, town, or county) <u>9605 Hated Rd Balto Ind</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>2/11/67</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>				23. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> ADDRESS 24a. REC'D BY REGISTRAR <u>FEB 10 1967</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

MEDICAL CERTIFICATION

2/8/67
DATE SIGNED

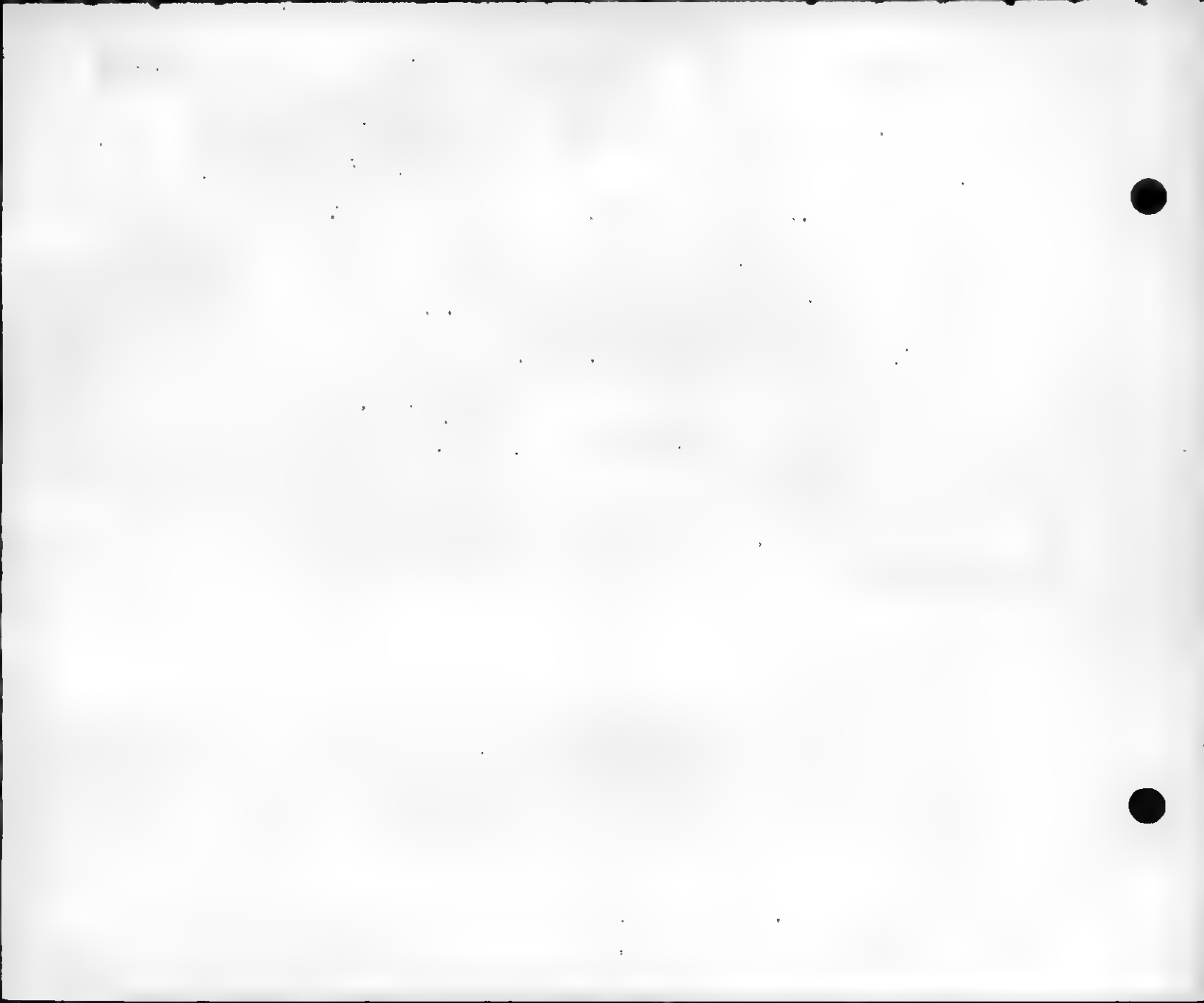


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01819						01814					
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Boxer Hill Rd., Near Padonia d.</i>						d. STREET ADDRESS <i>Boxer Hill Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>MacCallum</i> Last <i>Gray</i>						4. DATE OF DEATH Month <i>February</i> Day <i>17</i> Year <i>1967</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 2, 1896</i>		9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrical Engineer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Consulting Engr.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Scotland</i>				12. CITIZEN OF WHAT COUNTRY? <i>Am</i>	
13. FATHER'S NAME <i>Robert Gray</i>						14. MOTHER'S MAIDEN NAME <i>Mary Farmer</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Family records</i>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lung</i> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>May 26, 1966</i> to <i>Feb 16, 1967</i> , that (I) (we) last saw the deceased alive on <i>Feb 17, 1967</i> , and that death occurred at <i>11</i> M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Thurmond Kriger</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Feb 17, 1967</i>			
22c. PHYSICIAN'S NAME (Type) <i>Thurmond Kriger</i>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>				23b. DATE THEREOF <i>Feb. 20, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR <i>John Burns' Sons, To son, Maryland</i>						25a. REC'D BY REGISTRAR <i>FEB 23 1967</i>		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate is to be retained by the hospital or attending physician. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ribbon ~~from page 1~~. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

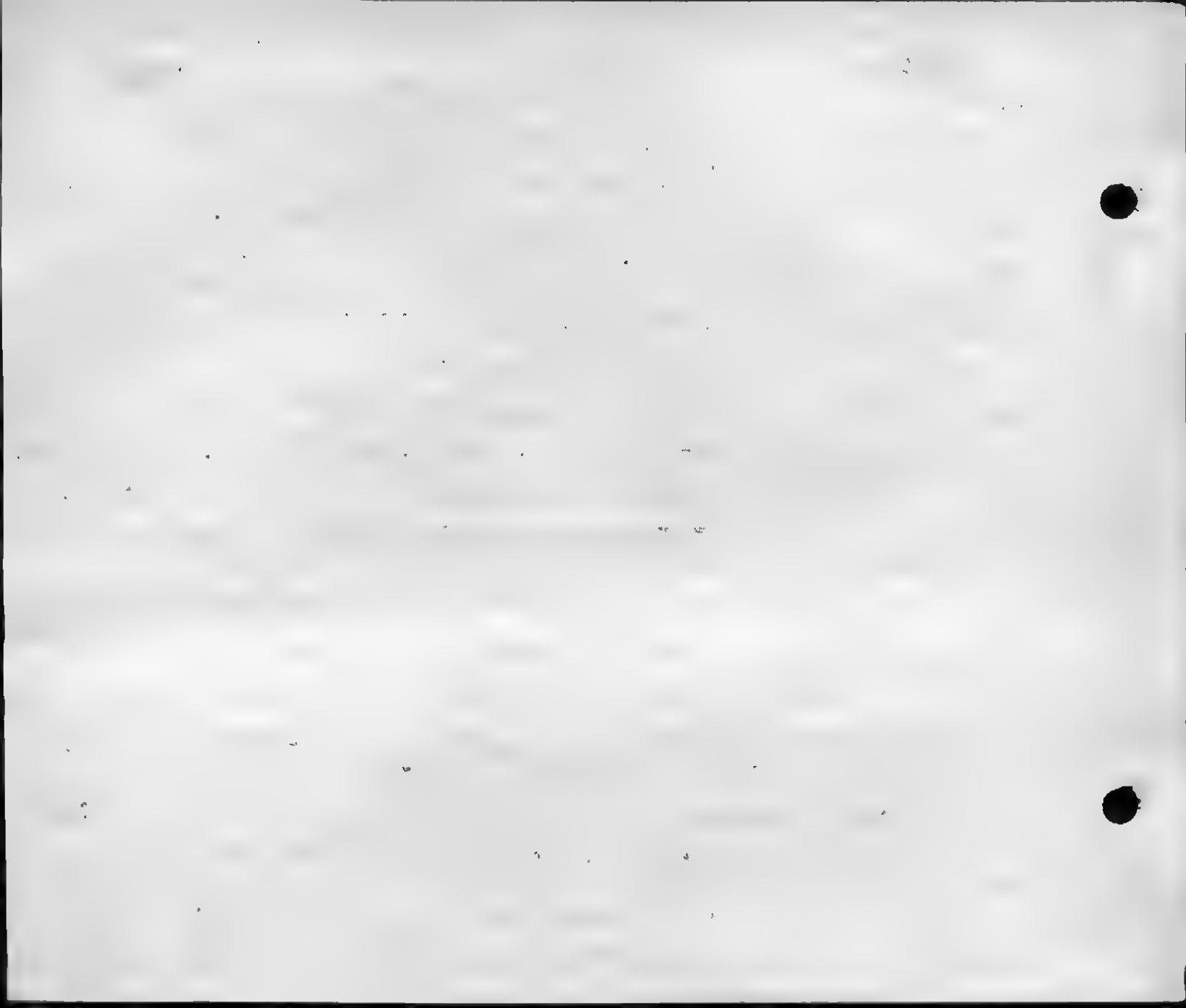
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01820

01815

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shady Nook Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 532 West Mulberry St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary H. Griffith		4. DATE OF DEATH February 20, 1967		9. AGE (In years last birthday) 93 yrs. IF UNDER 1 YEAR: Months 2 Days 4 Hours 1 Min.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (County & State, or foreign country) Virginia			
13. FATHER'S NAME Robinson Walker		14. MOTHER'S MAIDEN NAME Lucy Robinson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-12-8968 D		17. INFORMANT Mr. Joseph R. Griffith			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) arteriosclerosis Cardiovascular (c) Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/24, 1954 to 2/20, 1967, that (I) last saw the deceased alive on 2/19, 1967, and that death occurred at 7:30 M, from the causes and on the date stated above							
22a. SIGNATURE CLIFF RATLIFF, JR. M.D.		22b. ADDRESS 4605 EDMONDSON AVE NE		22c. DATE SIGNED 2/24/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 2/23/1967		23c. NAME OF CEMETERY OR CREMATORY Harmony Grove Cemetery			
23d. LOCATION (City, town or county) Harmony Grove, Virginia		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tink...		25a. REC'D BY REGISTRAR FEB 23 1967		25b. REGISTRAR'S SIGNATURE Charles J...			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01821

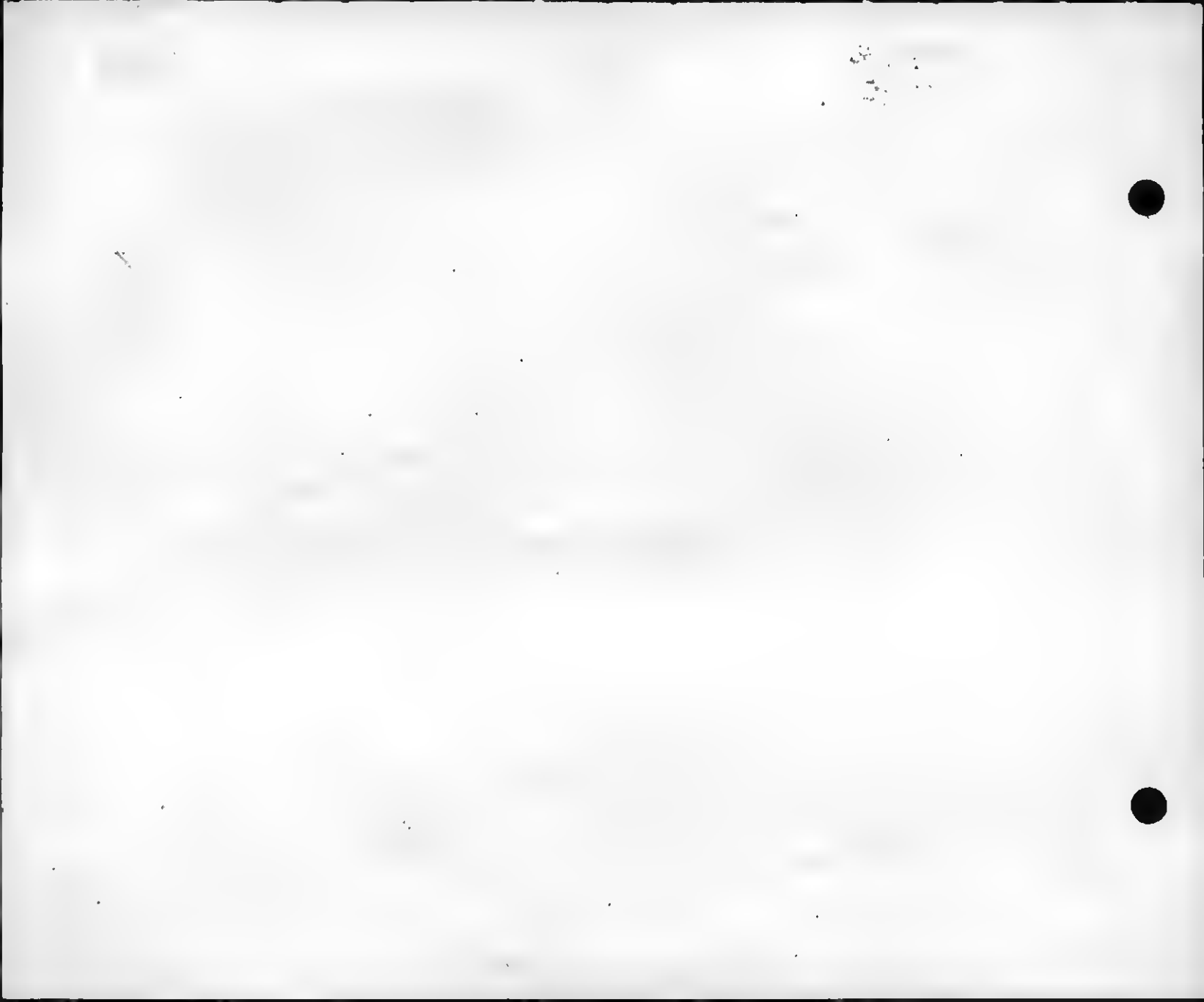
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01816

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL BALTIMORE</u> c. LENGTH OF STAY IN 1b <u>20 YR</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1305 AINTREE RD.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL BALTIMORE</u> d. STREET ADDRESS <u>1305 AINTREE RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM ELLSWORTH GROFF</u> First Middle Last			4. DATE OF DEATH <u>2</u> <u>17</u> <u>1967</u> Month Day Year				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 17, 1913</u>	9. AGE (in years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER AIRCRAFT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AIRCRAFT-ROCKETS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>EASTON PENNSYLVANIA USA</u>			
13. FATHER'S NAME <u>WILLIAM GROFF</u>			14. MOTHER'S MAIDEN NAME <u>HATTIE WURZBACHER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES NO RECALLED</u>		16. SOCIAL SECURITY NO. <u>087-09-9814</u>		17. INFORMANT <u>WIFE, NATALIE GROFF</u> Address <u>1305 AINTREE RD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u> <u>20 YR</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>FEB</u> , 19 <u>67</u> , to <u>FEB</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>FEB 11</u> , 19 <u>67</u> , and that death occurred at <u>11:45</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel I. O'Mansky</u>			22b. DATE SIGNED <u>FEB 18 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL I. O'MANSKY</u>			22d. ADDRESS <u>8523 LOCHRAVEN BLVD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2-20-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>COCKEYSVILLE, MD.</u>			
23d. LOCATION (City, town or county) (State)		23e. REGISTRAR'S SIGNATURE <u>James J. Judge</u>					
24. FUNERAL DIRECTOR <u>W.M. COOK-BROOKS, TOLSON, INC. TOLSON 4 MD</u>		25a. REC'D BY REGISTRAR <u>FEB 20 1967</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

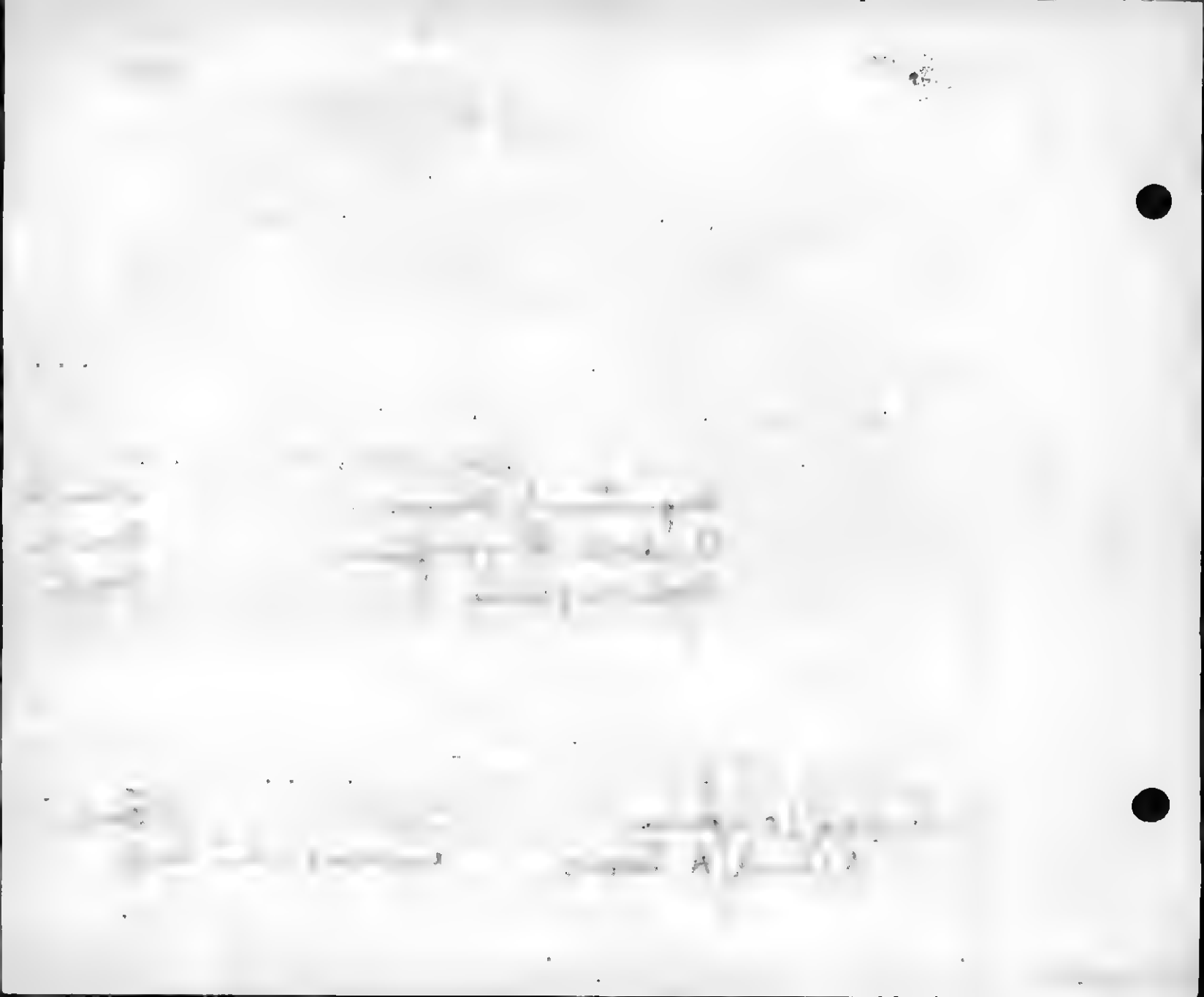
01822

CERTIFICATE OF DEATH

01817

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS 414 Enfield Road	
3 NAME OF DECEASED (Type or print) First Middle Last Mary Kathleen HALES		4 DATE OF DEATH Month Day Year 2 5 19 67	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-66
9. AGE (In years last birthday) yrs 9 30		10. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) Dependent	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Gratt Hales, Jr.		14. MOTHER'S MAIDEN NAME Martha Eileen Buell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no --		16. SOCIAL SECURITY NO none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Aspirational Pneumonia DUE TO (b) Cerebral Atrophy DUE TO (c) Hydrocephalus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. INTERVAL BETWEEN ONSET AND DEATH 2 months 8 months 9 months		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 12-30, 1966, to 2-5, 1967, that (if we) last saw the deceased alive on 2-5, 1967, and that death occurred at 11:30 p.m. from causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 6 Feb 67	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones		22d. ADDRESS Rosewood State Hosp	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/10/67	
23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		23d. LOCATION (City or Town) (County) (State) Owings Mills, Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.		25a. REC'D BY REGISTRAR DATE 2-3-14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. Page 2 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

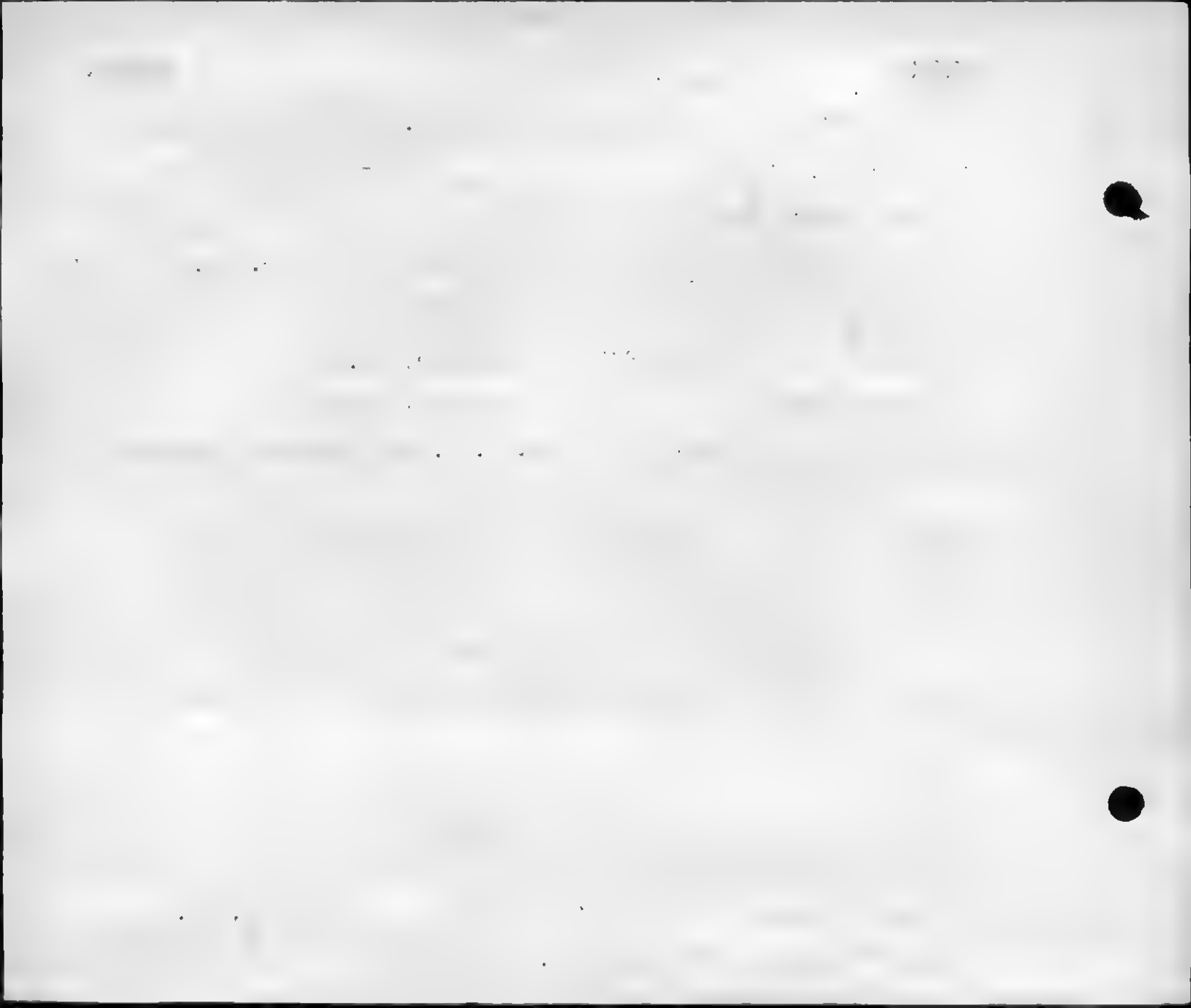
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01823

01818

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Balto. City c. LENGTH OF STAY IN b. City d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2516 Anders Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Baltimore City d. STREET ADDRESS 2516 Anders Road		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR CHARLES HALLAM		4. DATE OF DEATH Month Feb. Day 14, Year 1967		5. SEX M	
6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/20/1890	
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 7 Days 6		11. IF UNDER 24 HRS. Hours 6 Mins. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10b. KIND OF BUSINESS OR INDUSTRY Post office		11. BIRTHPLACE (County & State, or foreign country) Chester, Pa.	
13. FATHER'S NAME Atlantis Hallam		14. MOTHER'S MAIDEN NAME Rachael Thompson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 216 32 6272		17. INFORMANT Mrs. A. C. Hallam Address 2516 Anders Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Nephrosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last Arteriosclerotic Vascular Dis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a, b, or c.					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month May Day 13 Year 1967 Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from May 1967 to Feb 14, 1967 that (I) (we) last saw the deceased alive on 2/13/67 and that death occurred at 1:30 M, from the causes and on the date stated above.					
22a. SIGNATURE F.T. KASIK JR MD		22b. DATE 2/14/67		22c. ADDRESS 9005 Harford Rd	
22d. PHYSICIAN'S NAME (Type) F.T. KASIK JR MD		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS 9005 Harford Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
23d. LOCATION (City, town or county) Baltimore, Md.		23e. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC.		ADDRESS 715 Light St.		25a. REC'D BY REGISTRAR FEB 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 715 Light St.			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01824

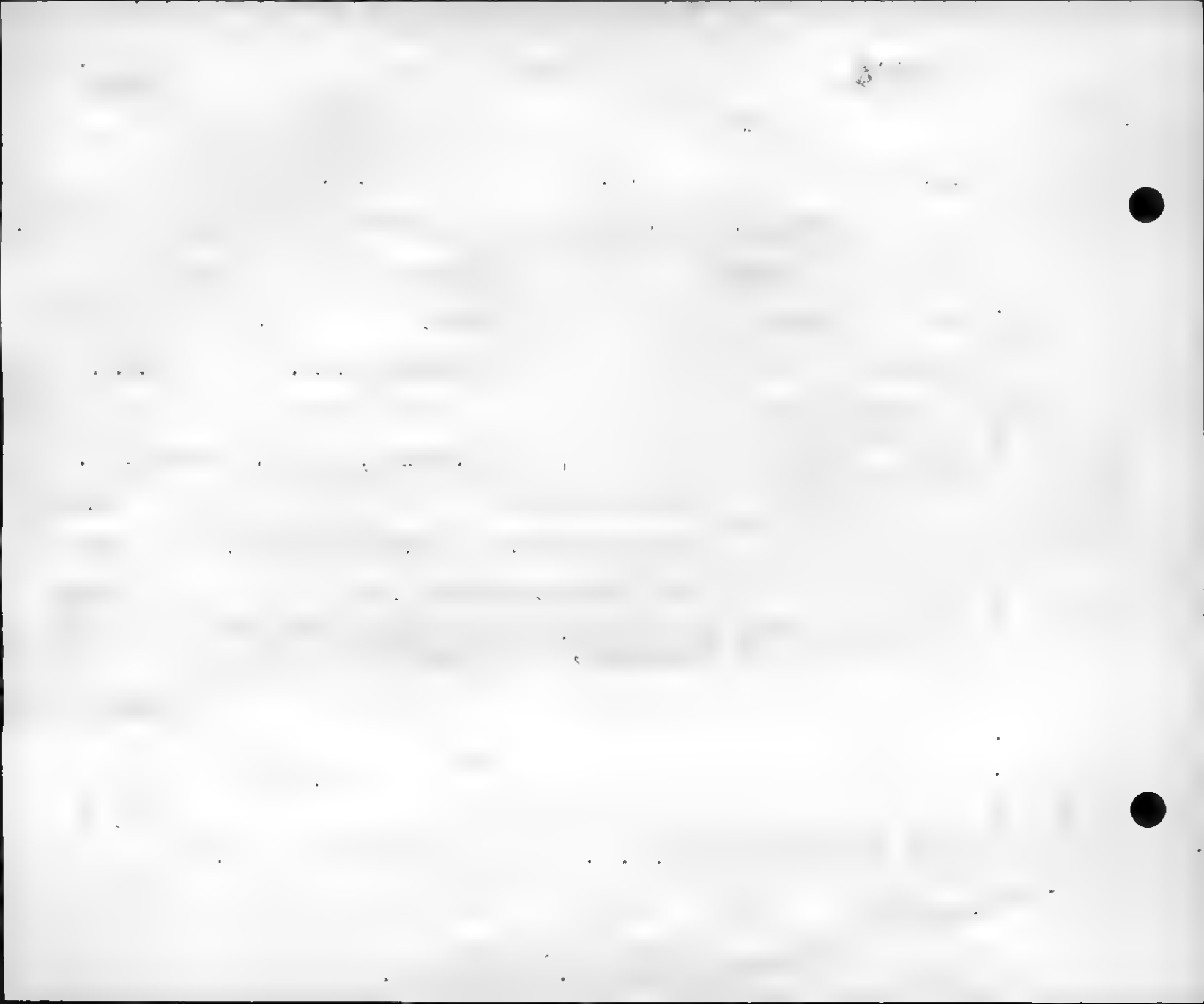
CERTIFICATE OF DEATH

01819

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SHIPPED TO: V. Y. SCOTT FUNERAL HOME, BLACKSTONE, VA.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY in 1b 40 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1626 ASHBURTON STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EVERETT HARDING				4. DATE OF DEATH Month Day Year 2/13/67 19			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/05		9. AGE (in years last birthday) 61 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) JETERSVILLE, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME EVERETT HARDING				14. MOTHER'S MAIDEN NAME MARIA WOODSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give year or dates of service) YES WW II		16. SOCIAL SECURITY NO 719 18 07 79		17. INFORMANT Address CLIN. RECORDS, VA HOSP. FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5021 STATUS ASTHMATICUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) PNEUMONIA, UNDETERMINED ORGANISM, BILATERAL DUE TO (c) CHRONIC OBSTRUCTIVE BRONCHITIS						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE, REMOTE MYOCARDIAL INFARCTION; GOUT; ADRENAL CORTICAL HYPOFUNCTION, SEC TO THERAPY						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/4/67 , 19 to 2/13/67 , 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/13/67 , 19, and that death occurred at 12:55A from causes and on the date stated above.							
22a. SIGNATURE <i>Neilson Neilson</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/15/67	
22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 2-19-67		23c. NAME OF CEMETERY OR CREMATORY Blackstone Cmt		23d. LOCATION (City or town) (County) (State) Blackstone VA	
24. FUNERAL DIRECTOR <i>W. Wilson</i>				ADDRESS WILSON FUNERAL HOME		25a. REC'D BY REGISTRAR FC 20 1967	
				25b. REGISTRAR'S SIGNATURE <i>W. Wilson</i>			
ORLEANS ST. BALTIMORE, MD.							



9-10-67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01825

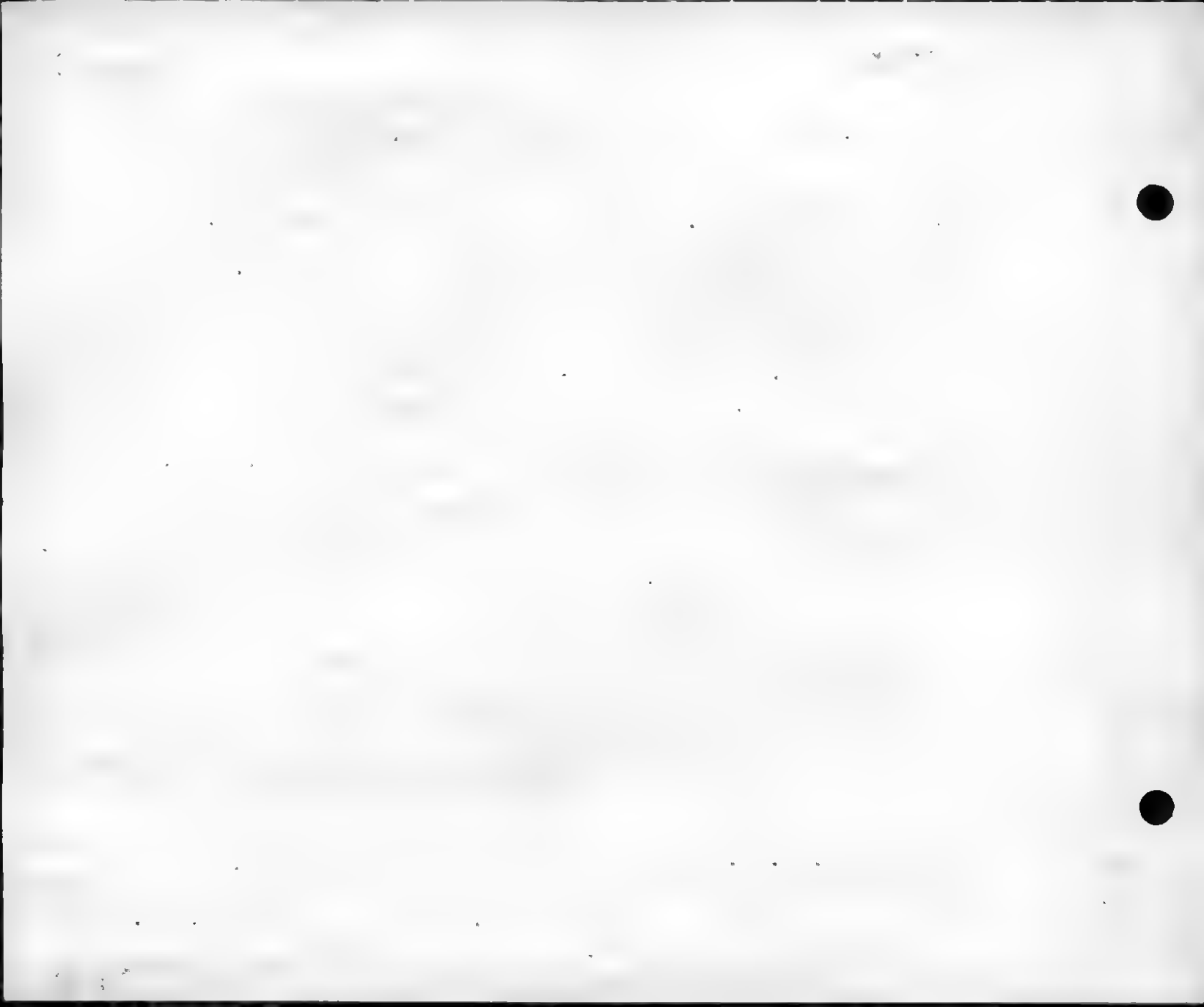
CERTIFICATE OF DEATH

01820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY 21234	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3042 California Ave.		d. STREET ADDRESS 3042 California Ave.	
3. NAME OF DECEASED (Type or print) First RUSSELL Middle FRANKLIN Last HARE		4. DATE OF DEATH Month Feb. Day 22 Year 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/1913
9. AGE (In years last birthday) 53 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Md. Bolt & Nut Co.		10b. KIND OF BUSINESS OR INDUSTRY Millers Station, Md	
11. BIRTHPLACE (County & State, or foreign country) Millers Station, Md		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Clarence Hare		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 184-12-5616	
17. INFORMANT Virginia Minor Hare, wife, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rheumatic heart disease with DUE TO (b) mitral & aortic insufficiency DUE TO (c) arthritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 6, 1966 to Feb 22 1967 that (I) (we) last saw the deceased alive on Feb 16 1967 and that death occurred at 10:25 M. from causes and on the date stated above			
22a. SIGNATURE A. M. Bacon		22b. DATE SIGNED 2/24/67	
22c. PHYSICIAN'S NAME (Type) Dr. A. M. Bacon		22d. ADDRESS 2810 Taylor Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/27/67	
23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25a. REC'D BY REGISTRAR FEB 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 3331 Brehms Lane	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

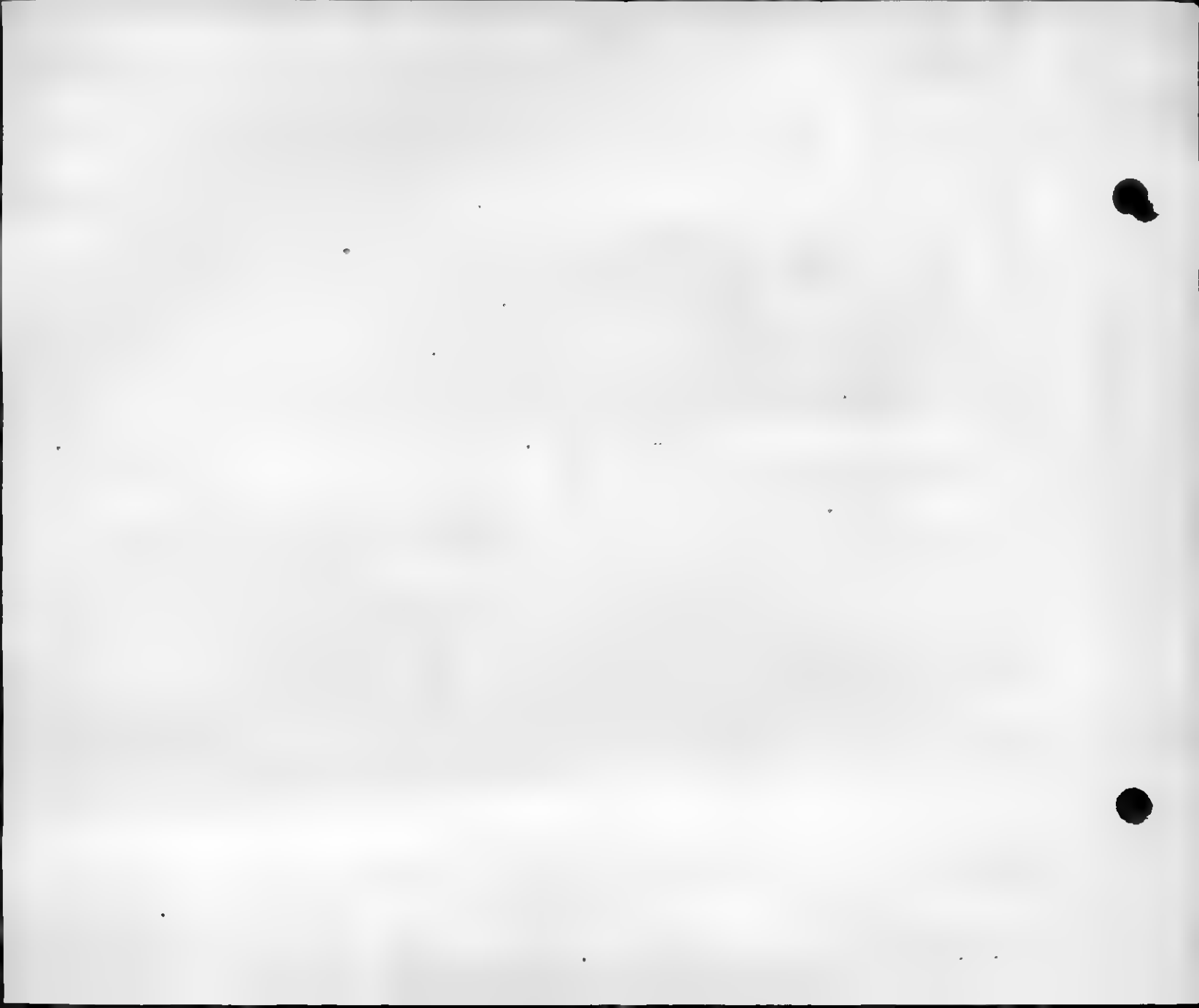
CERTIFICATE OF DEATH

Reg. Dist. No. 01821

01826

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Res. dence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) Foxleigh Nursing Home		d. STREET ADDRESS 21 W. Chatsworth	
3. NAME OF DECEASED (Type or print) First Bessie Middle Norris Last Harvey		4. DATE OF DEATH Month February Day 28 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1880
9. AGE (In years last birthday) yrs 86		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto. City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nicholas D. Norris		14. MOTHER'S MAIDEN NAME Ida Stocksdales	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-30-7014	
17. INFORMANT Miss. Elizabeth N. Harvey		Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO A.S.H.D. + high arterial sd Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pyelonephritis (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hour 20 yrs 45 hrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 49 to Feb 28, 1967 , that I last saw the deceased alive on Feb 26, 1967 , and that death occurred at 8 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Linson Rd. Garretts Mill. Md DATE SIGNED 2/28/67 ACTUAL SIGNATURE Palmer F. Williams M.D. PHYSICIAN'S NAME (Type) PALMER F. P. Williams			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/67	
22c. NAME OF CEMETERY OR CREMATORY Green Mount		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		24a. REC'D BY REGISTRAR MAR 3 1967	
ADDRESS Reisterstown, Md.		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain page 4 and 5. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

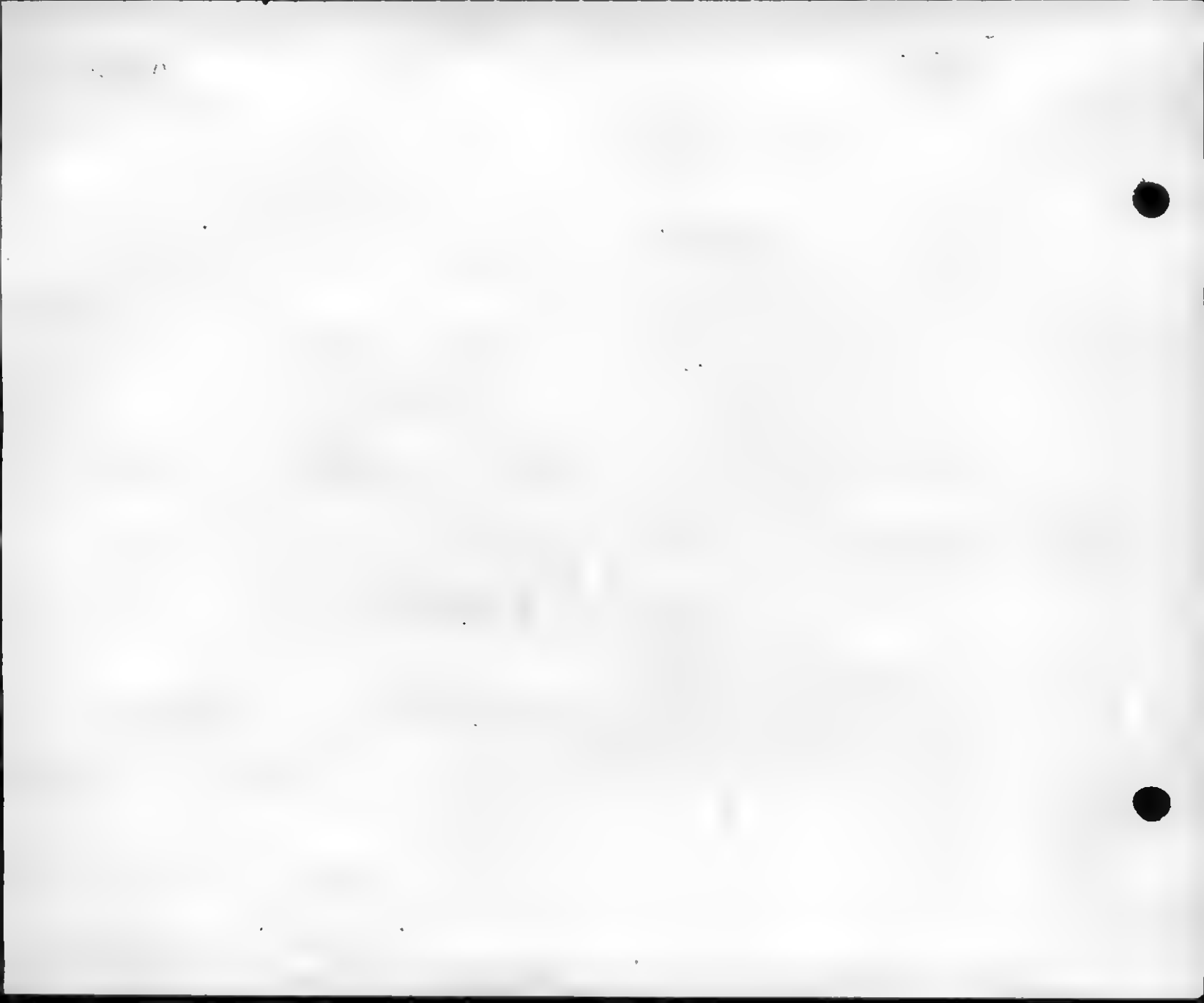
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01827

CERTIFICATE OF DEATH

01822

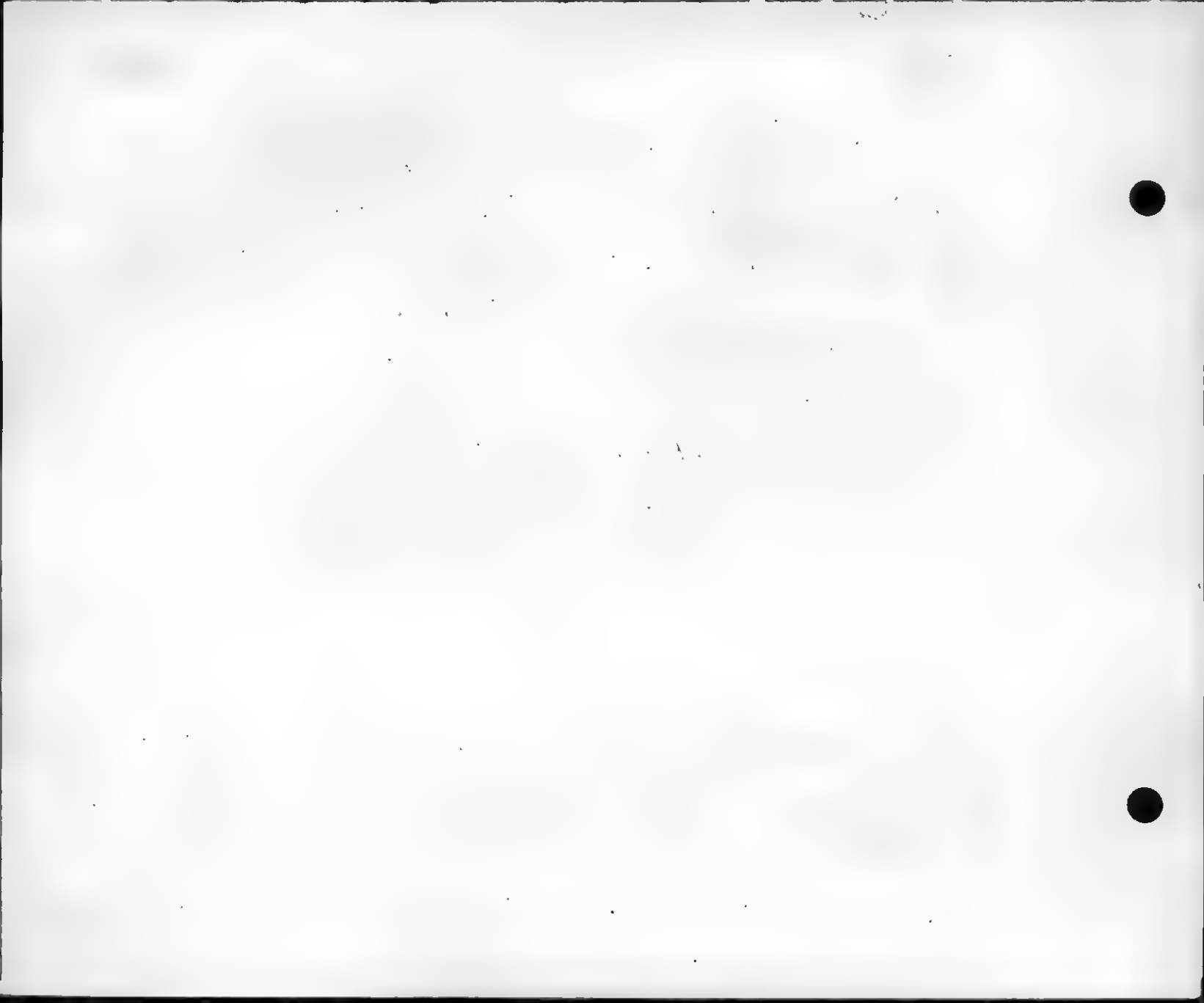
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Carroll and Monkton Rds.</u>						d. STREET ADDRESS <u>Carroll and Monkton Rds.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LYNN</u> First <u>Lydia</u> Middle <u>Harvey</u> Last <u>HARVEY</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>28</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 6, 1886</u>		9. AGE (in years last birthday) <u>80</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Widow lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13. FATHER'S NAME <u>Henry Harvey</u>				14. MOTHER'S MAIDEN NAME <u>Laura Pearce</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Family records</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. Disease</u> <u>7.221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> , 19 <u>67</u> to <u>2/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/28</u> , 19 <u>67</u> , and that death occurred at <u>2</u> P.M., from causes and on the date stated above.									
22a. SIGNATURE <u>A. M. France</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>2/28/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. M. France</u>				22d. ADDRESS <u>PARKTON, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 2, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monkton Methodist Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Monkton Maryland</u>			
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
018228						018223						
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY			Baltimore			a. STATE			b. COUNTY			
			MARYLAND			Maryland			Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						
Lutherville						Lutherville						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?			
1619 Greenspring Drive						1619 Greenspring Drive			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year			
C. LaRue Havens						February 15, 1967			19			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.		
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 20, 1897		69 yrs.		Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
elder - retired				Self employed		New York			USA			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME						
James Havens						Helen Humphrey						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			Address			
No				None		187-14-3650		Family records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a)										Acute Myocardial Infarction		
DUE TO										17 YR.		
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Art. sclerotic C.V. Disease		
DUE TO												
(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED?		
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								
21. I certify that (I) (this hospital) attended the deceased from JAN 18 1967 to 2-15-67, that (II) we last saw the deceased alive on 2-15-1967, and that death occurred on 2-15-67, from the causes and on the date stated above.												
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
Donald O Wood M.D.									2-17-67			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)				
Burial			Feb. 18, 1967		Grace-Falls Road Methodist			Cockeysville, Maryland				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
John Burns' Sons, Towson, Maryland						DATE FEB 20 1967			Yellow's Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01829 CERTIFICATE OF DEATH 01824

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SHADY ROCK NURSING HOME</u>				d. STREET ADDRESS <u>382 CHAPEL VIEW RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>C</u> Last <u>HAYS</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 12 - 1882</u> 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL TEACHER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>266-76-3862</u>		17. INFORMANT <u>Francis Hoskin</u>		Address <u>382 CHAPEL VIEW RD, ELLICOTT CITY, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO (b) <u>CARCINOMATOSIS</u> DUE TO (c) <u>CARCINOMA - BREAST</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 YR</u> <u>5 YR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-3</u> , 19 <u>66</u> to <u>2-14</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2-13</u> , 19 <u>67</u> , and that death occurred at <u>12:05</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>John V. Thoden</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John V. Thoden</u>				22d. ADDRESS <u>ELLICOTT CITY, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREEN HILL CEM</u>		23d. LOCATION (City, town or county) (State) <u>Johnstown, OHIO</u>	
24. FUNERAL DIRECTOR <u>RE. H. G. BOTTEN</u>				ADDRESS <u>ELLICOTT CITY, MD</u>		25a. REC'D BY REGISTRAR <u>Charles J. J.</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles J. J.</u>		DATE <u>FEB 17 1967</u>	

MEDICAL CERTIFICATION

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 MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01830

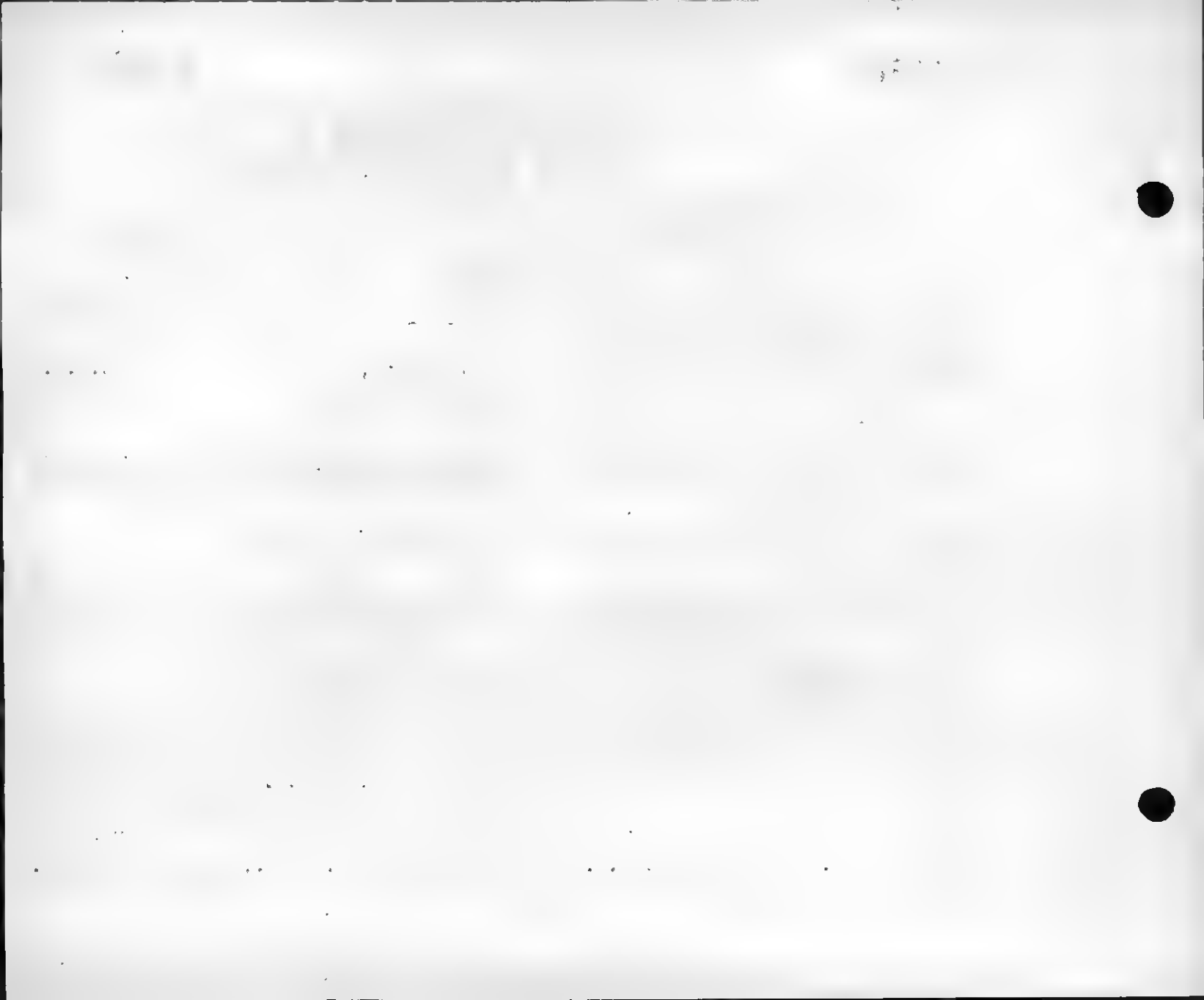
CERTIFICATE OF DEATH

01825

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 10 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. STREET ADDRESS 7004 Boxwood Road	
3. NAME OF DECEASED (Type or print) First Israel Middle Jacob Last HERTZBERG		4 DATE OF DEATH Month 2 Day 6 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-27-55
9 AGE (In years last birthday) 11 yrs.		10 IF UNDER 1 YEAR Months 2 Days 6 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Irving Hertzberg		14. MOTHER'S MAIDEN NAME Esther Tenenbaum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shigellosis DUE TO Shigellosis from mental retardation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Profound mental retardation DUE TO Mongolism (c) Mongolism		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Progeria?		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 3-24 , 19 66 , to 2-6 , 19 67 , that (X) (we) last saw the deceased alive on 2-6 , 19 67 , and that death occurred at 8:54 Macon causes and on the date stated above.			
22a. SIGNATURE D. Crosby Greene M.D.		22b. DATE SIGNED 2-6-67	
22c. PHYSICIAN'S NAME (Type) D. Crosby Greene, M.D.		22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/7/67	
23c. NAME OF CEMETERY OR CREMATORY Rosewood		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24 FUNERAL DIRECTOR Sylvia S. Livingston Inc. Baltimore, Md		25a. REC'D BY REGISTRAR FEB 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their release remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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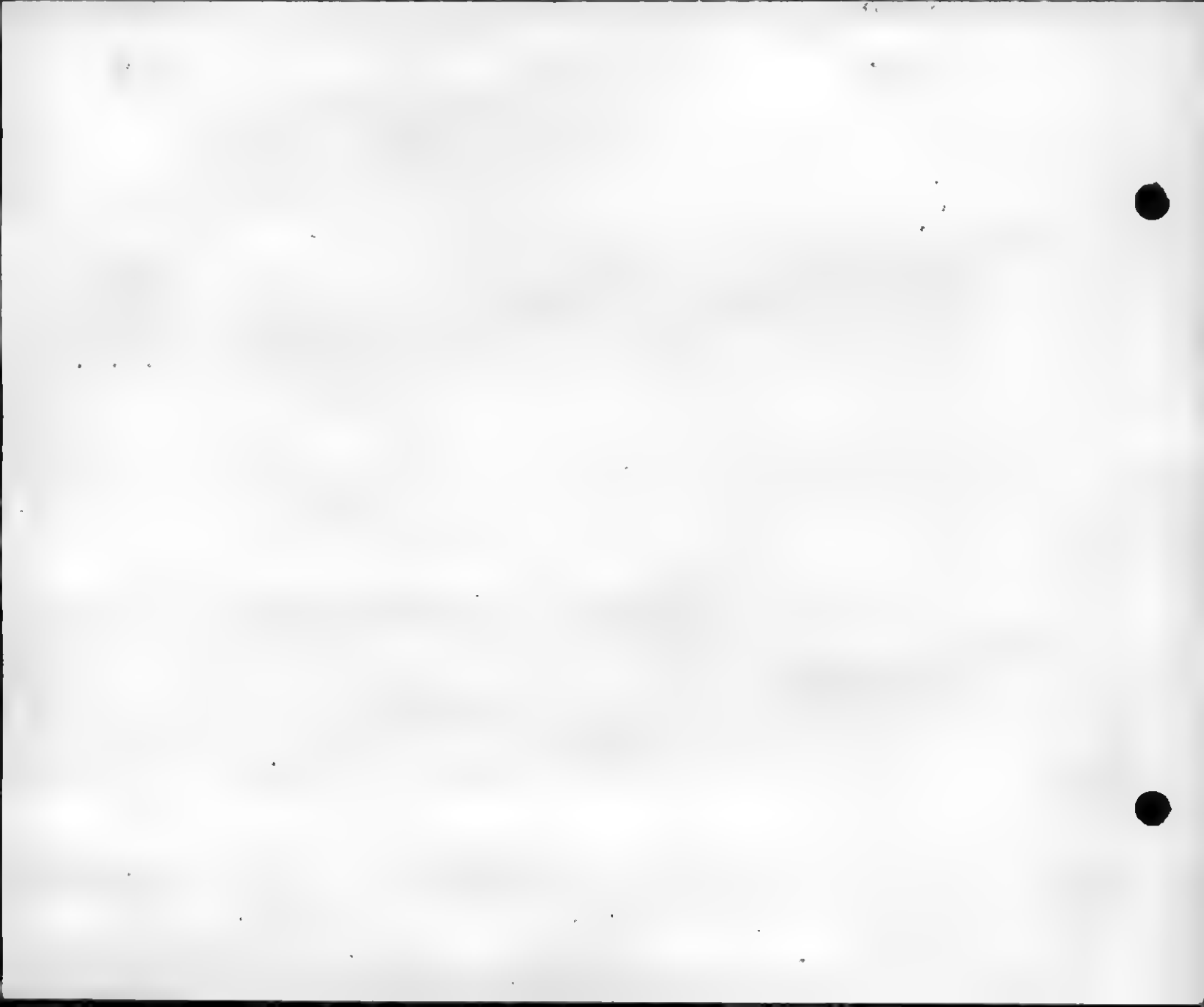
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-19-2011 BY 60322 UCBAW

CERTIFICATE OF DEATH

01826

1 PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. LENGTH OF STAY IN 1b 2 YEARS		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before adm ssion) a. STATE Maryland b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenarm Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) Sister Mary Eustelle Hess						4 DATE OF DEATH Month February Day 17 Year 1967		5 SEX Female		6 COLOR OR RACE W		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8 DATE OF BIRTH July 12, 1885				9 AGE (In years last birthday) 82 yrs.				10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (Country & State, or foreign country) Baltimore, Maryland					
12 CITIZEN OF WHAT COUNTRY? U. S. A.						13 FATHER'S NAME John Hess						14 MOTHER'S MAIDEN NAME Mary Ann Fisher					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no						16. SOCIAL SECURITY NO. 217-51-9781						17 INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of breast DUE TO Infiltration axillary vein DUE TO Pulmonary & General bone metastasis												INTERVAL BETWEEN ONSET AND DEATH 1 year 1 year					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)													
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from April 20, 1966 , to Feb 17, 1967 , that (I) (we) last saw the deceased alive on Feb 5, 1966 , and that death occurred at 6:50 P.M. from causes and on the date stated above																	
22a. SIGNATURE S. G. Sullivan						22b. DATE SIGNED 2-22-67				22c. PHYSICIAN'S NAME (Type) S.G. Sullivan							
22d. ADDRESS 1129 St Paul St Baltimore 2 Md																	
23a. BURIAL, CREMATION, REMOVA (Specify) Burial				23b. DATE THEREOF 2-20-1967		23c. NAME OF CEMETERY OR CREMATORY Sister's Cemetery				23d. LOCATION (City or Town) (County) (State) Glen Arm, Maryland							
24. FUNERAL DIRECTOR Raymond J. Curran						25a. REC'D BY REGISTRAR DATE FEB 28 1967				25b. REGISTRAR'S SIGNATURE Charles Judge							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

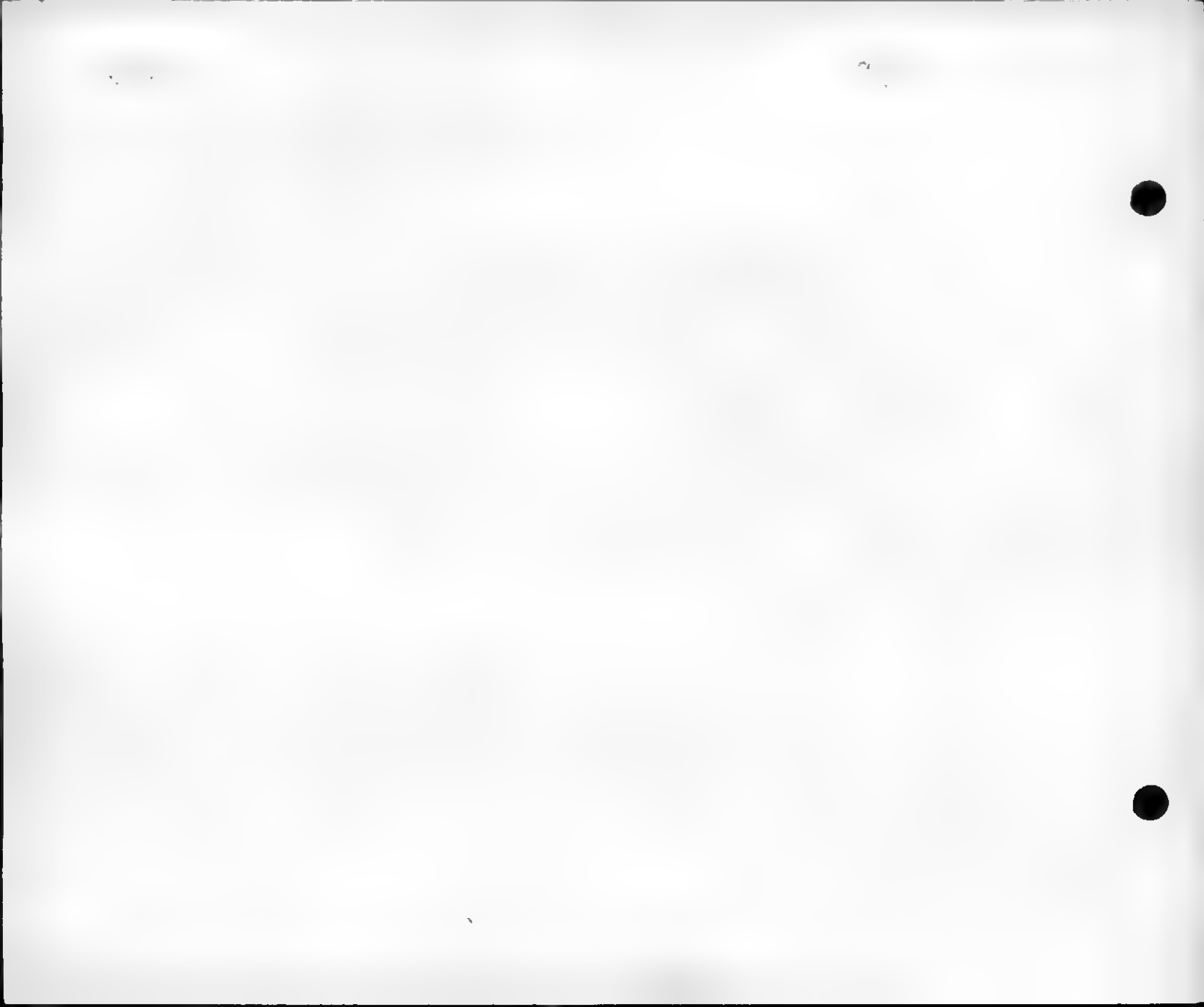
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01832

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01827

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			c. LENGTH OF STAY IN TB			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7446 MANCHESTER RD.</u>				d. STREET ADDRESS <u>7446 MANCHESTER RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY W. HICKMAN</u>				4. DATE OF DEATH Month Day Year <u>FEB 10 1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 5, 1906</u>	9. AGE (In years last birthday) <u>60</u> yrs	10. UNDER 1 YEAR Months Days Hours Min		11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES HICKMAN</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA AMOS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO <u>218-05-375</u>		17. INFORMANT <u>EMMA HICKMAN</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V- DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>AK</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M.B. Davis</u>		EXAMINER'S NAME (Type) <u>M.B. DAVIS MD-6800 MURNINGTOWN</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23c. BURIAL: REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB. 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		23d. LOCATION (City or town, County) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u>		ADDRESS <u>300 MACE</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>W. J. Judge</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01833

CERTIFICATE OF DEATH

01828

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>21204</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN IT <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u>				d. STREET ADDRESS <u>4308 Forestview Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frederick R. Arnold Hightman</u>				4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-1976</u>		9. AGE (In years last birthday) <u>91</u> yrs	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lutheran Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Burkittsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Luther</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN Loretta Arnold</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NA</u>		16. SOCIAL SECURITY NO. <u>213-36-8407H</u>		17. INFORMANT Address <u>Rev. Schylze - Pope & Marluth Aves</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u> DUE TO (b) <u>aspiration pneumonia or infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> , 19 <u>67</u> , to <u>Feb 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 11</u> , 19 <u>67</u> , and that death occurred at <u>6:45 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Mario B. Ines M.D.</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>2-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARIO B. INES M.D.</u>		22d. ADDRESS <u>GBMC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-15-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Lorraine Burdick</u>				ADDRESS <u>36 2401 Belair Road</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 17 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>William Judge</u>			



CERTIFICATE OF DEATH

01834

Reg. Dist. No. 01829

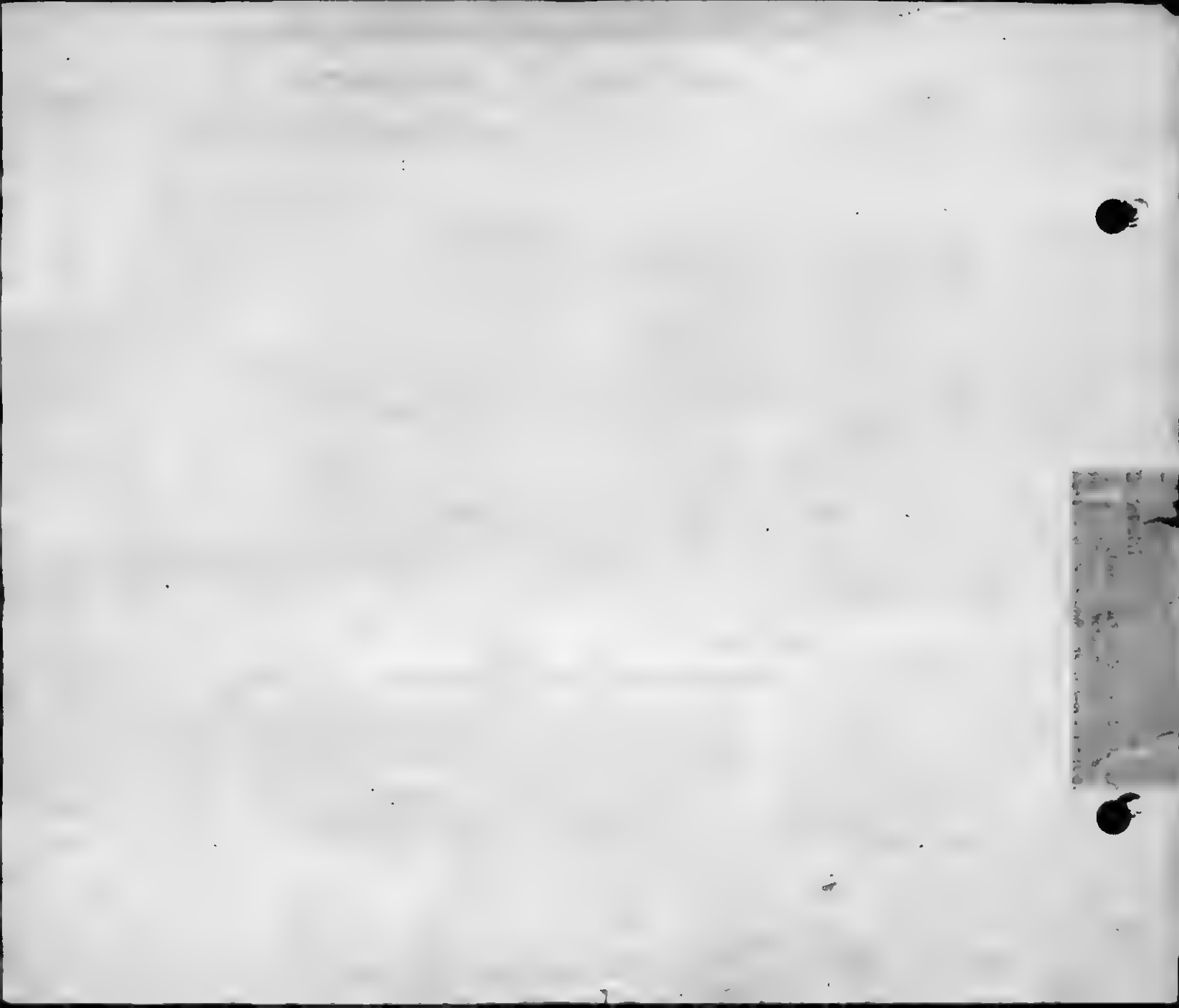
INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 11M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>SPARROWS POINT</u>				TOWN <u>SPARROWS POINT 19,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>807 J Street</u>				STREET ADDRESS (If rural give location) <u>807 J Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Benjamin</u> (First) <u>Hill</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>February 24</u> <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>November 14, 1897</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
				<u>3</u>	<u>8</u>	<u>0</u>	<u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Plant</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joe Hill</u>				14. MOTHER'S MAIDEN NAME <u>Annie Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-07-6541</u>		17. INFORMANT & ADDRESS <u>Annie Hill 807 J. Street</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
3X IMMEDIATE CAUSE (A) <u>Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac Failure</u>				<u>3 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Carcinoma Lung</u>				<u>1 yr.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>December 14, 1965</u> to <u>February 24, 1967</u> that I last saw the deceased alive on <u>February 24, 1967</u> and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William C. Hale</u>				ADDRESS (Street, city, town, state) <u>140 Oak Ave. S. in Del. Kent, 2/24/67</u>			
DATE THEREOF <u>2-28-67</u>				NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem Park</u>			
BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				LOCATION (City, town, or county) (State) <u>Arbutus Md.</u>			
24. REC'D BY REGISTRAR <u>FEB 28 1967</u>		REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Morton E. Dy. H.F.H.</u>		ADDRESS <u>1701 Laurens</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01835

CERTIFICATE OF DEATH

Reg. Dist. No. 01830

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Randallstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Randallstown</u>		d. STREET ADDRESS <u>Holbrook Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Holbrook Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bettie</u> Middle <u>S.</u> Last <u>Holbrook</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1881</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ezra Holbrook</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-38-9849</u>	
17. INFORMANT <u>Mr. Herbert Holbrook - Randallstown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Arterial hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/10/67</u> , to <u>2/11/67</u> , that I last saw the deceased alive on <u>2/10/67</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Randallstown, Md.</u> DATE SIGNED <u>2/11/67</u> ACTUAL SIGNATURE <u>Wm. E. Martin</u> PHYSICIAN'S NAME (Type) <u>Wm. E. Martin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-13-67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woods Chapel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Haight</u>		24a. REC'D BY REGISTRAR <u>Charles Judge</u> 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 (M)

01836

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01831

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Maryland</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1813 Aberdeen Road</u>		d. STREET ADDRESS <u>1813 Aberdeen Road</u>	
4 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ethel</u> First <u>M</u> Middle <u>Holokai</u> Last		4 DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>CAU</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>08-20-24</u> <u>42</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>URBAN RENOVATION</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Harlan Co. Ky</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Robert Lee White</u>		14 MOTHER'S MAIDEN NAME <u>GARLAND</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Patient's Chart</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL SUBARACHNOID HEMORRHAGE</u> DUE TO <u>RUPTURED BERRY ANEURYSM OF</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE <u>CIRCLE OF WILLIS</u> lost (b) <u>3 DAYS</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-10</u> , 1967, to <u>2-13</u> , 1967, that (I) (we) last saw the deceased alive on <u>2-13</u> , 1967, and that death occurred at <u>2:30 P.M.</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Henri T. Voorstad</u>		22b DATE SIGNED <u>2-13-67</u>	
22c PHYSICIAN'S NAME (Type) <u>HENRI T. VOORSTAD</u>		22d ADDRESS <u>G.B.M.C.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>2/17/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Balto. Natl. Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24 FUNERAL DIRECTOR <u>Barby Caranough</u>		25a REC'D BY REGISTRAR <u>FEB 16 1967</u>	
ADDRESS <u>6601 Frederick Ave</u>		25b REGISTRAR'S SIGNATURE <u>J. Charles Young</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01837

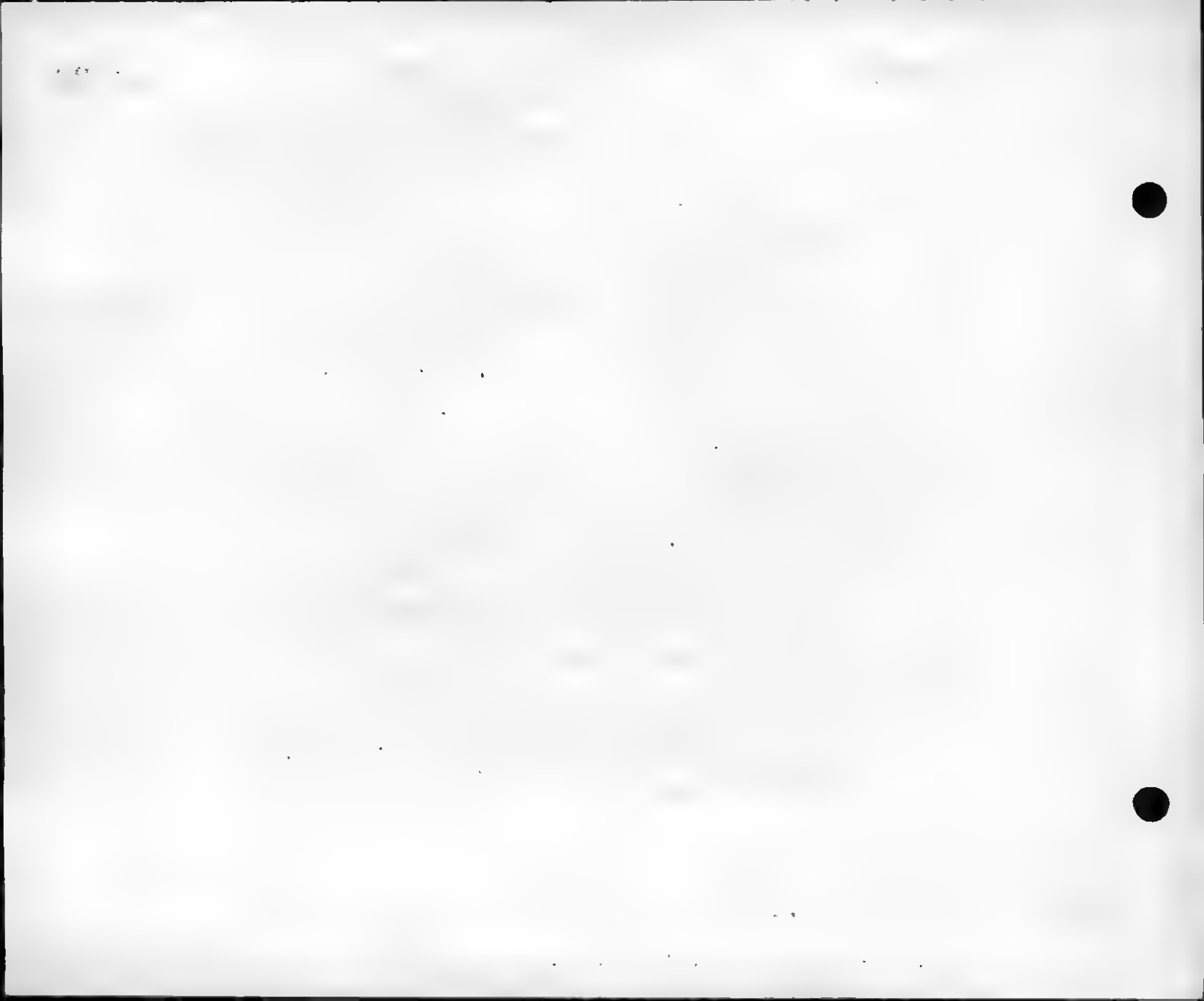
CERTIFICATE OF DEATH

01832

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Alleghany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>4 yrs. 10 mo.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		d. STREET ADDRESS <u>78 Mechanic Street.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bonnie Blink Masonic Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Janet</u> Middle <u>A.</u> Last <u>Hotchkiss</u>		4 DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1886</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Longacoring, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Peter McFarland</u>		14 MOTHER'S MAIDEN NAME <u>Janet Muir</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>214-14-7972</u>	
17 INFORMANT <u>Records of Md. Masonic Home, Cockeysville</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1 Bronchopneumonia & arteriosclerosis</u> DUE TO (b) <u>3 Pulmonary Metastasis</u> DUE TO (c) <u>3 Skin lesions secondary to Burn</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1965</u> , 19 <u>65</u> , to <u>Feb 3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 3</u> , 19 <u>67</u> , and that death occurred at <u>4:45</u> A.M., from causes and on the date stated above			
22a. SIGNATURE <u>JAMSHID HAMED.</u>		22b. DATE SIGNED <u>FEB 3, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED.</u>		22d. ADDRESS <u>MASONIC HOME</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Alleghany Cemetery-Frostburg, Maryland</u>	23d. LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md. 21204</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>FEB 6 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

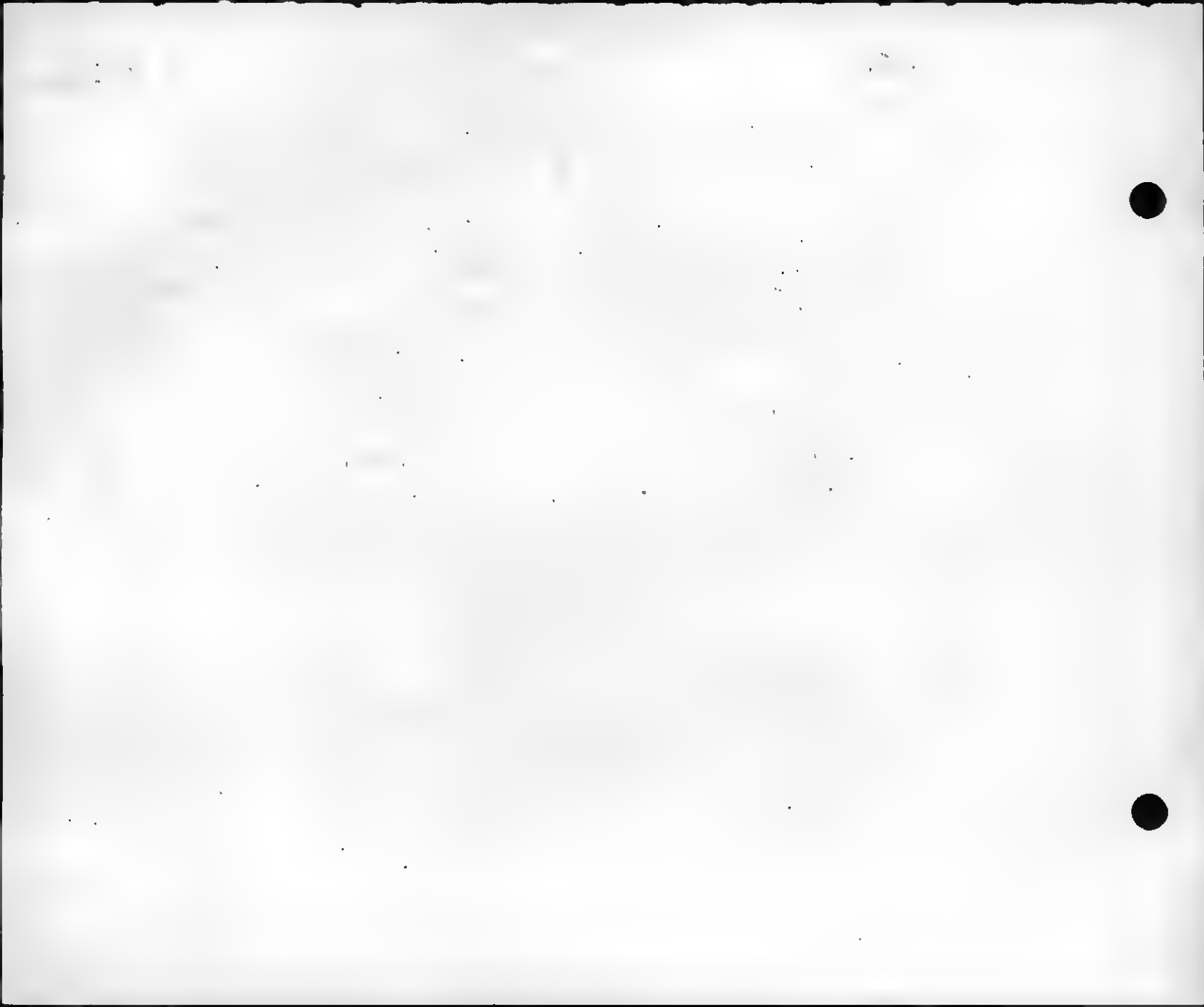
VR A15 (4)
20M 1/65

01838

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01833

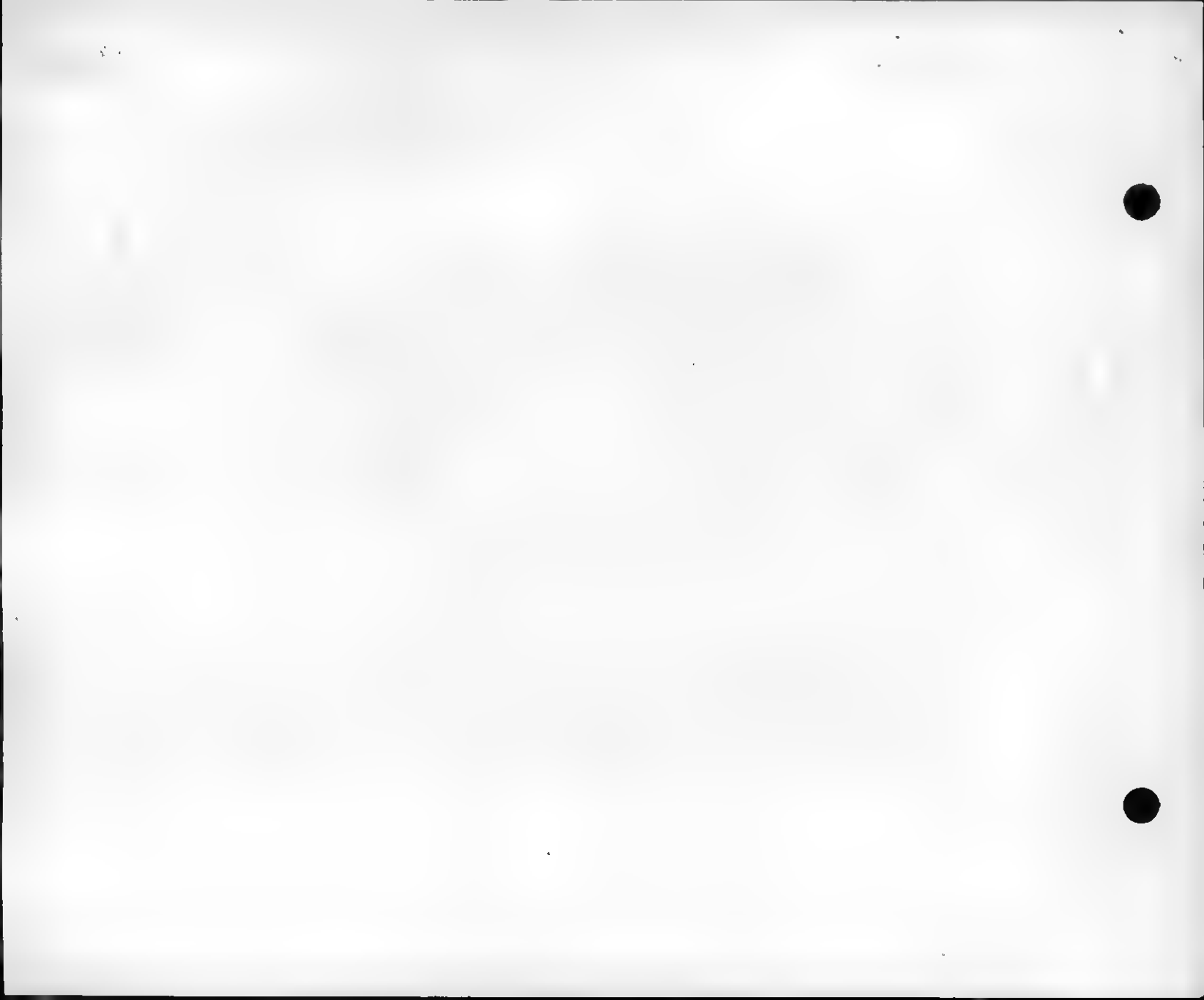
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>6 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St Joseph Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u> d. STREET ADDRESS <u>2703 FIFTH AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>J</u> Last <u>Franksky</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 5 1911</u>	9. AGE (in years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Traf. Rate Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Crown C & S</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Frank Hradsky</u>			14. MOTHER'S MAIDEN NAME <u>Anna Troch</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-0329</u>	17. INFORMANT <u>Family records</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO (b) <u>Acute bacterial myocardial infarction</u> DUE TO (c) <u>Acute bacterial myocardial infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe anemia</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u> </u> , to <u>June</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>2/21</u> 19 <u>67</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>E.P. Coffey Jr</u>			22b. DATE SIGNED <u>2/21/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>E.P. Coffey Jr</u>			22d. ADDRESS <u>3100 ST PAUL ST</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem</u>	23d. LOCATION (City, town or county) (State) <u>Balto Md</u>		
24. FUNERAL DIRECTOR <u>CHAS. F. EVANS & SON</u>		ADDRESS <u>8802 Harford Rd</u>		25a. REC'D BY REGISTRAR <u>Charles J. J...</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>
DATE <u>FEB 27 1967</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01839 CERTIFICATE OF DEATH 01831

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>619 Horncrest Rd</u>		e. STREET ADDRESS <u>619 Horncrest Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>E.</u> Middle <u>MILTON</u> Last <u>HUETER JR</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soleman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E Hueter</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Deichmann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-0-2263</u>	
17. INFORMANT <u>Lillian B Hueter</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardio-Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1740</u>	20f. (City or town) (County) (State) <u>Fet</u> <u>1967</u>
21. I certify that (I) (this hospital) attended the deceased from <u>1940</u> , to <u>Feb</u> , 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>Feb 5</u> , 19 <u>67</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William R Helfrich</u>		22b. DATE SIGNED <u>2-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William R Helfrich</u>		22d. ADDRESS <u>3006 Roland Ave, Balt 16, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-9-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley</u>	23d. LOCATION (City, town or county) (State) <u>BALTO MD</u>
24. FUNERAL DIRECTOR <u>Mrs. F. Evans & Son</u>		25a. REC'D BY REGISTRAR <u>5802 Hanford Rd</u>	
25b. REGISTRAR'S SIGNATURE <u>William R Judge</u>		DATE <u>FEB 14 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

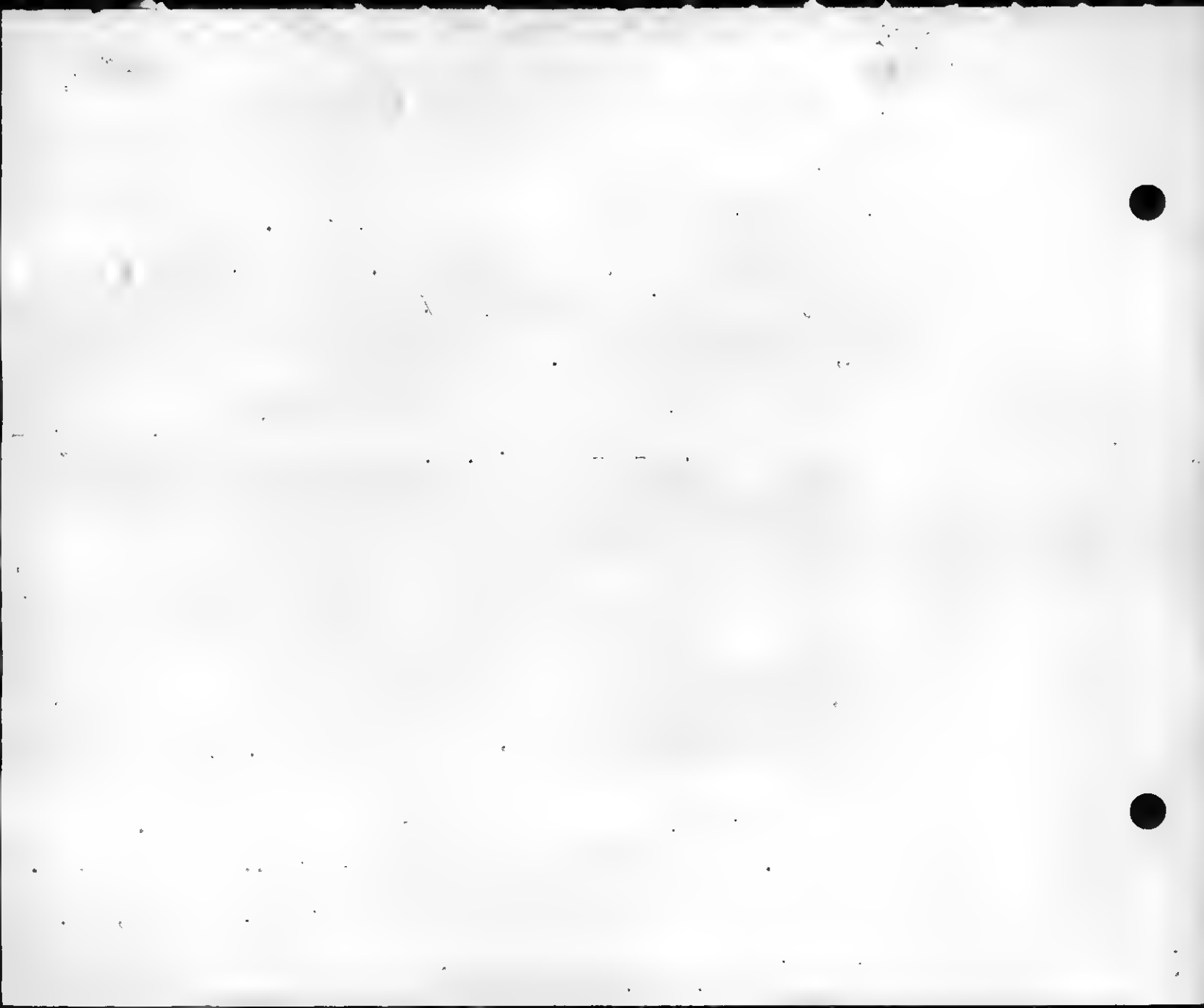
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01840

01835

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8431 Greenway Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 8431 Greenway Rd. d. STREET ADDRESS 8431 Greenway Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PAUL H. HUTCHINS, Sr.		4. DATE OF DEATH Month February Day 7 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/19/1901
9. AGE (In years) 65 IF UNDER 1 YEAR: Months 03 Days 1 Hours 00 Min. 00		10. BIRTHPLACE (County & State, or foreign country) Maryland	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk, Alcoa Steamship Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Lee Hutchins		14. MOTHER'S MAIDEN NAME Johanna Conroy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-18-3830	
17. INFORMANT Mrs. B. Martha Hutchins		Address 8431 Greenway Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary atherosclerosis 11241 DUE TO (b) atherosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. , 19 59 , to Dec. , 19 66 , that (I) (we) last saw the deceased alive on 12-22-1966 , and that death occurred at 12-22-1966 M, from the causes and on the date stated above.			
22a. SIGNATURE E. Schnitzer		22b. DATE SIGNED Feb. 8, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Eugene Schnitzer		22d. ADDRESS 3904 Hanover St., Baltimore 25, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 2/10/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	23d. LOCATION (City, town or county) (State) Balto., County, Md.
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		25a. REC'D BY REGISTRAR FEB 14 1967	
ADDRESS 6500 York Rd. Balto., Md. 21212		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01841

CERTIFICATE OF DEATH

01836

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Catonsville 28			c. LENGTH OF STAY IN 1b 1 month		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines Nursing Home				d STREET ADDRESS 2830 Rona Road		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) Amy Alma Ireland				4 DATE OF DEATH Feb. 28 1967				
5 SEX Female		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 5-16-1883		
9. AGE (n years last birthday) 83 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleswoman			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) Calvert Co. Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cornelius O. Robinson				14. MOTHER'S MAIDEN NAME Ellen -				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16 SOCIAL SECURITY NO 214-14-7499		17. INFORMANT Alma Dorsey-702 E. Maple Rd. Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Ca of Lung 10:39 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Intestines DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 mos. 2 yrs.		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-25 , 1967, to 2-28 , 1967, that (I) (we) last saw the deceased alive on 2-27 , 1967, and that death occurred at 8:15 M, from causes and on the date stated above.								
22a. SIGNATURE Wilmer K. Gallagher				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher				22d. ADDRESS 6209 Frederick Ave - Baltimore Md.				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-1967		23c NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24 FUNERAL DIRECTOR Ellsworth Armacher				ADDRESS 400 Liberty Hgts Avenue		25a. REC'D BY REGISTRAR DATE MAR 2 1967		
				25b REGISTRAR'S SIGNATURE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

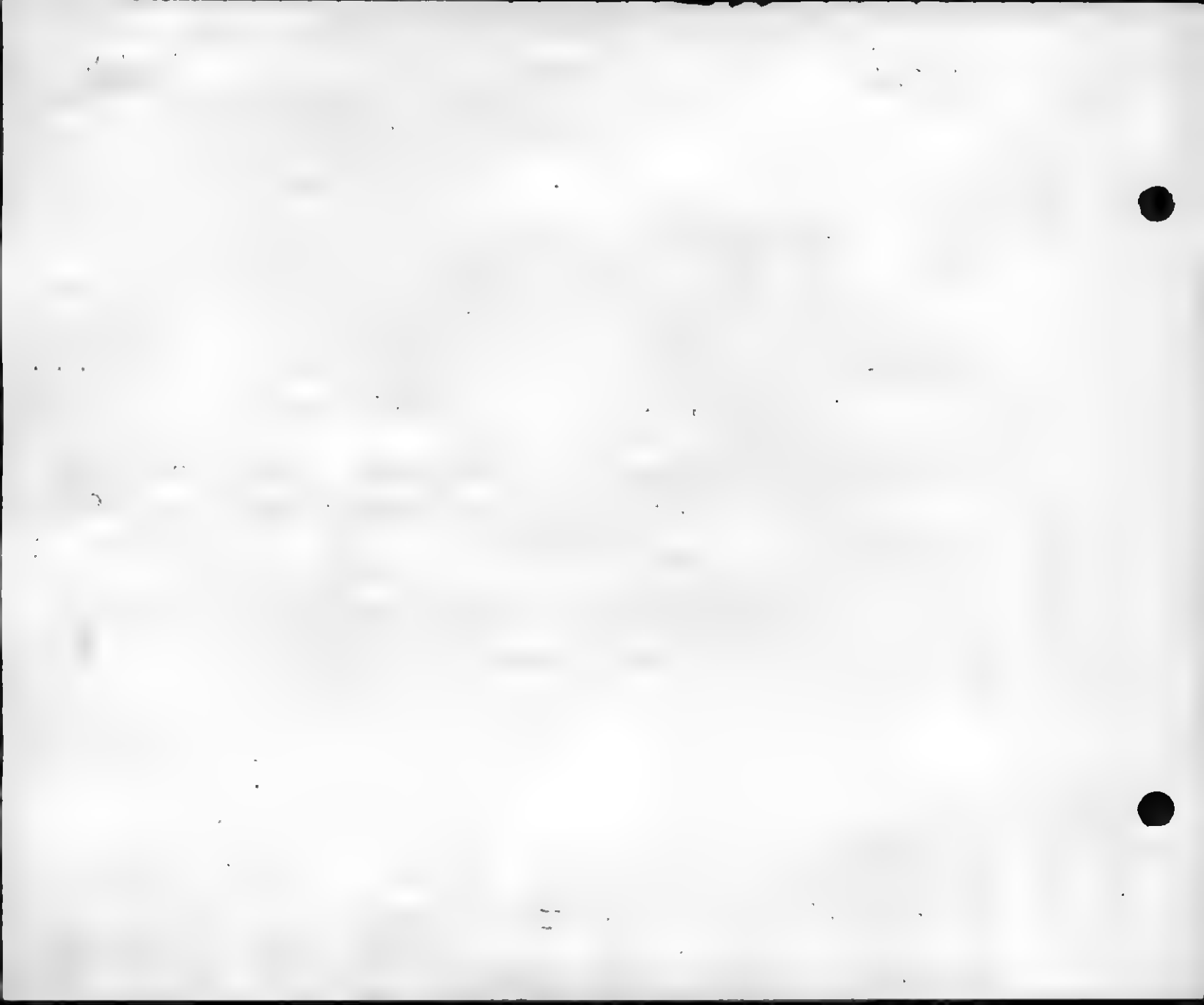
01842

CERTIFICATE OF DEATH

01837

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills			c. LENGTH OF STAY IN 1b 21 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit RURAL		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Hospital				d. STREET ADDRESS 			
3. NAME OF DECEASED (Type or print) First Middle Last Barbara Lee JACKSON				4. DATE OF DEATH Month Day Year 2 27 19 67			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-26-41		9. AGE (In years last birthday) 26 yrs	IF UNDER 1 YEAR Months Days Hours Min. 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none		11 BIRTHPLACE (County & State, or foreign country) Rising Sun, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Dennison Jackson, Jr.				14. MOTHER'S MAIDEN NAME Mary Alice Yocum			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no --		16 SOCIAL SECURITY NO none		17. INFORMANT Address Rosewood Records, Owings Mills, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Necrotizing bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Aspiration DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 days							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 8-15 , 19 45 , to 2-27 , 19 67 , that (X) (we) last saw the deceased alive on 2-27 , 19 67 , and that death occurred at 10:00 , from causes and on the date stated above.							
22a. SIGNATURE <i>Richard A. Jones</i>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 27 Feb 67	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones				22d. ADDRESS Rosewood state Hosp.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-1-1967		23c. NAME OF CEMETERY OR CREMATORY ELBERTER Cem		23d. LOCATION (City or town) (County) (State) Rising Sun Cecil Md.	
24 FUNERAL DIRECTOR Richard L. Goodie				25a. REC'D BY REGISTRAR DATE MAR 1 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

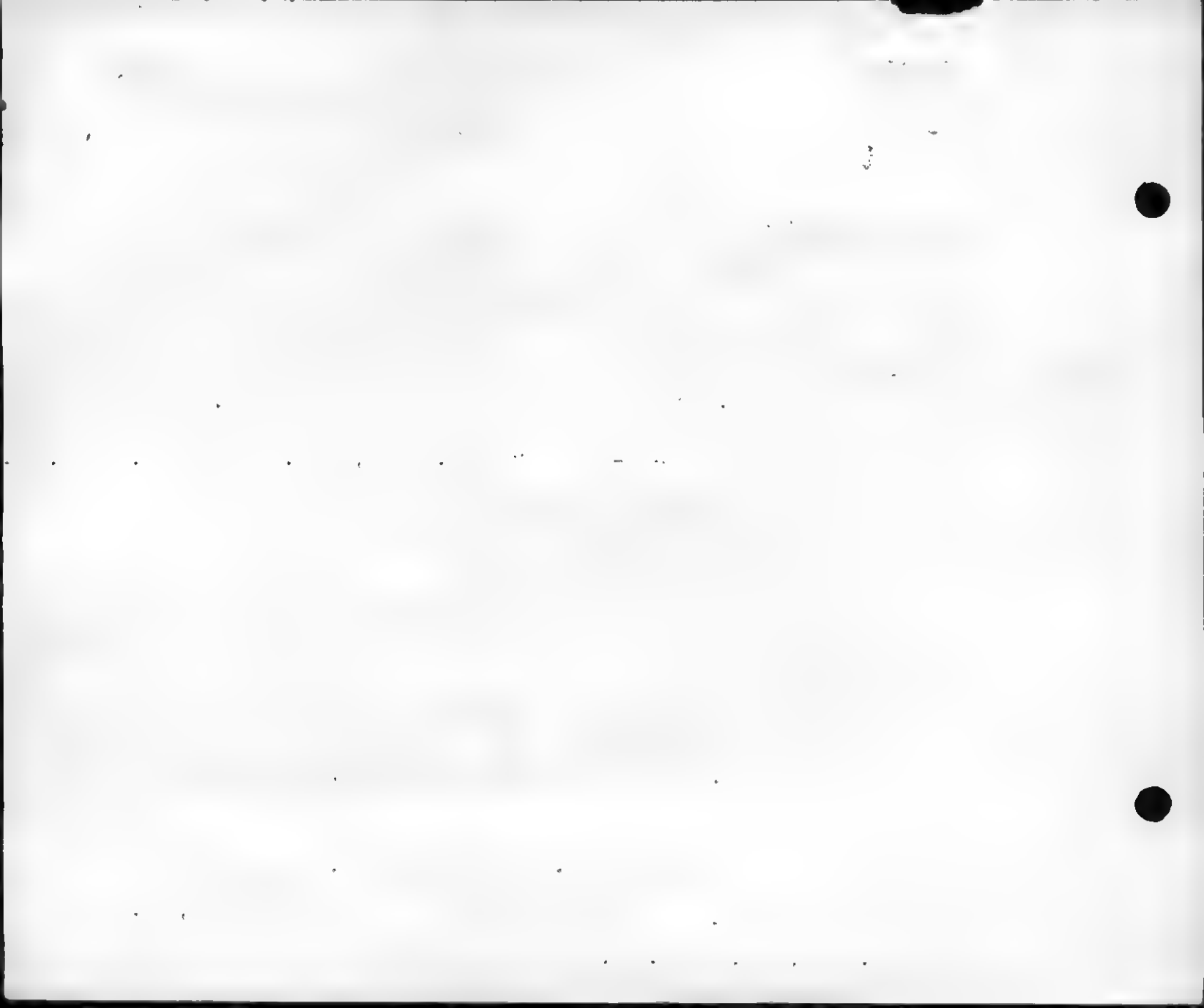
01843

CERTIFICATE OF DEATH

01838

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d STREET ADDRESS 5801 Chinguapin Parkway			
3 NAME OF DECEASED (Type or print) First Middle Last Mayme Virginia JAEGER				4 DATE OF DEATH Month Day Year February 20, 1967			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH January 23, 1885	9 AGE (In years and birthday) 82 yrs	f UNDER 1 YEAR Months Days		g UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Stauffer				14. MOTHER'S MAIDEN NAME Emma S. Ziegler			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 219-42-0483		17 INFORMANT Address James C. Burch, 15 W. Mulberry St. Balto. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the cecum. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21. I certify that II (this hospital) attended the deceased from 2/19/ , 19 67 , to 2/20/ , 19 67 , that II (we) last saw the deceased alive on 2/20/ , 19 67 , and that death occurred on 2/20/ , 19 67 , from causes and on the date stated above.							
22a SIGNATURE Lawrence F. Misanik, M.D.		22b. DATE SIGNED February 20, 1967		22c PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF 2/22/67.	23c NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a REC'D BY REGISTRAR DATE FEB 21 1967		25b. REGISTRAR'S SIGNATURE <i>Alvin J. Jones</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

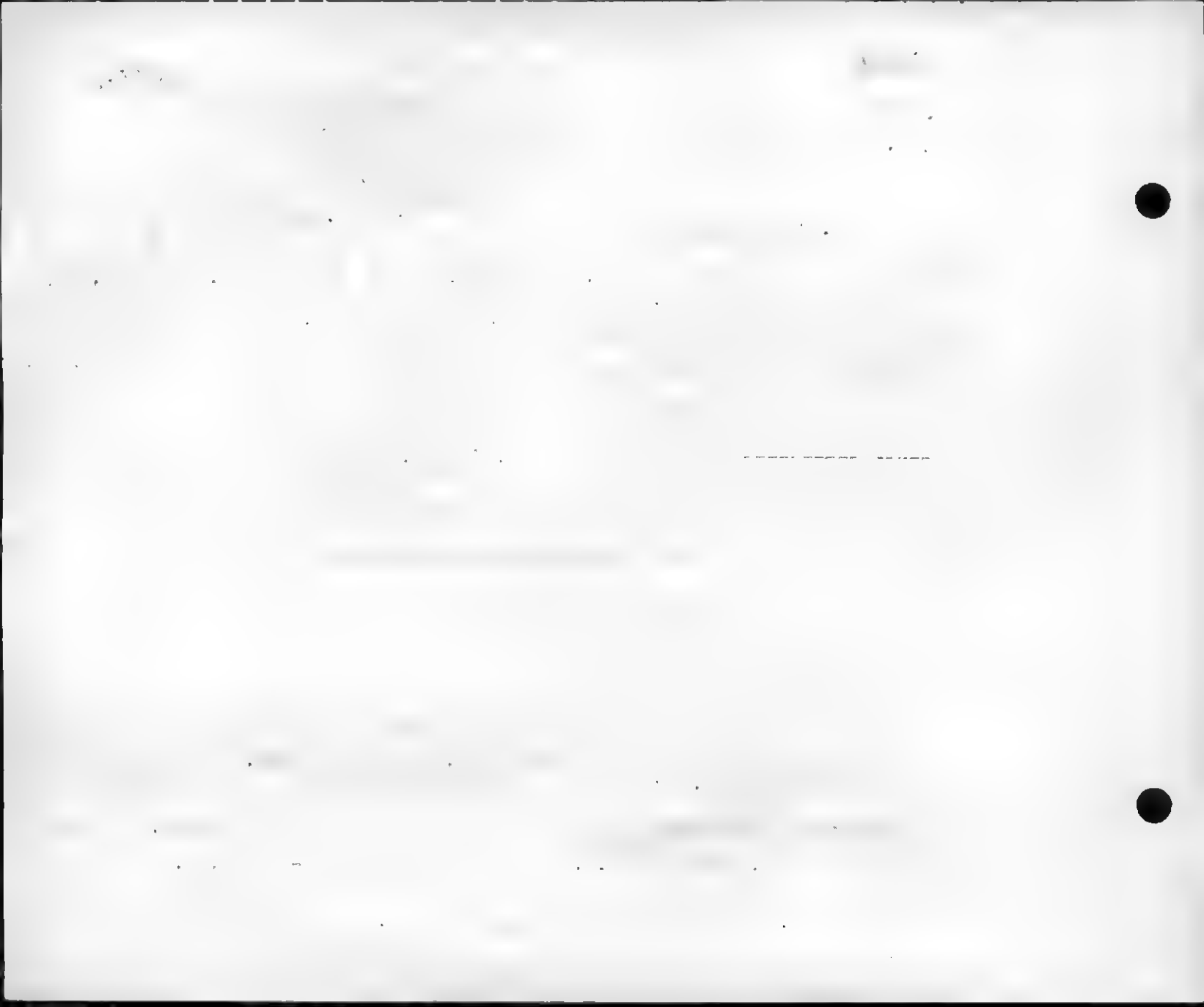
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01844

CERTIFICATE OF DEATH

01839

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 21218		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 2007 E. 32nd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frieda Middle M. Last Johanns				4. DATE OF DEATH Month Feb. Day 20 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-21-91	
9. AGE (In years lost birthday) yrs. 75		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State or foreign country) Germany	
12. C. T. ZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Geschwendt			
14. MOTHER'S MAIDEN NAME Margaret Otten				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO. 213-32-2858B				17. INFORMANT Address Mr. Karl F. Johans, Same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Heart Disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 4 , 1967, to Feb. 20 , 1967, that (I) (we) last saw the deceased alive on Feb. 20 , 1967, and that death occurred at 11:15 from causes on and on the date stated above.							
22a. SIGNATURE Ramon P. Lopez				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED Feb. 20 1967	
22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez M.D.				22d. ADDRESS 7620 York Road-Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB. 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park.		23d. LOCATION (City or Town) (County) (State) Baltimore Co., Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204				25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

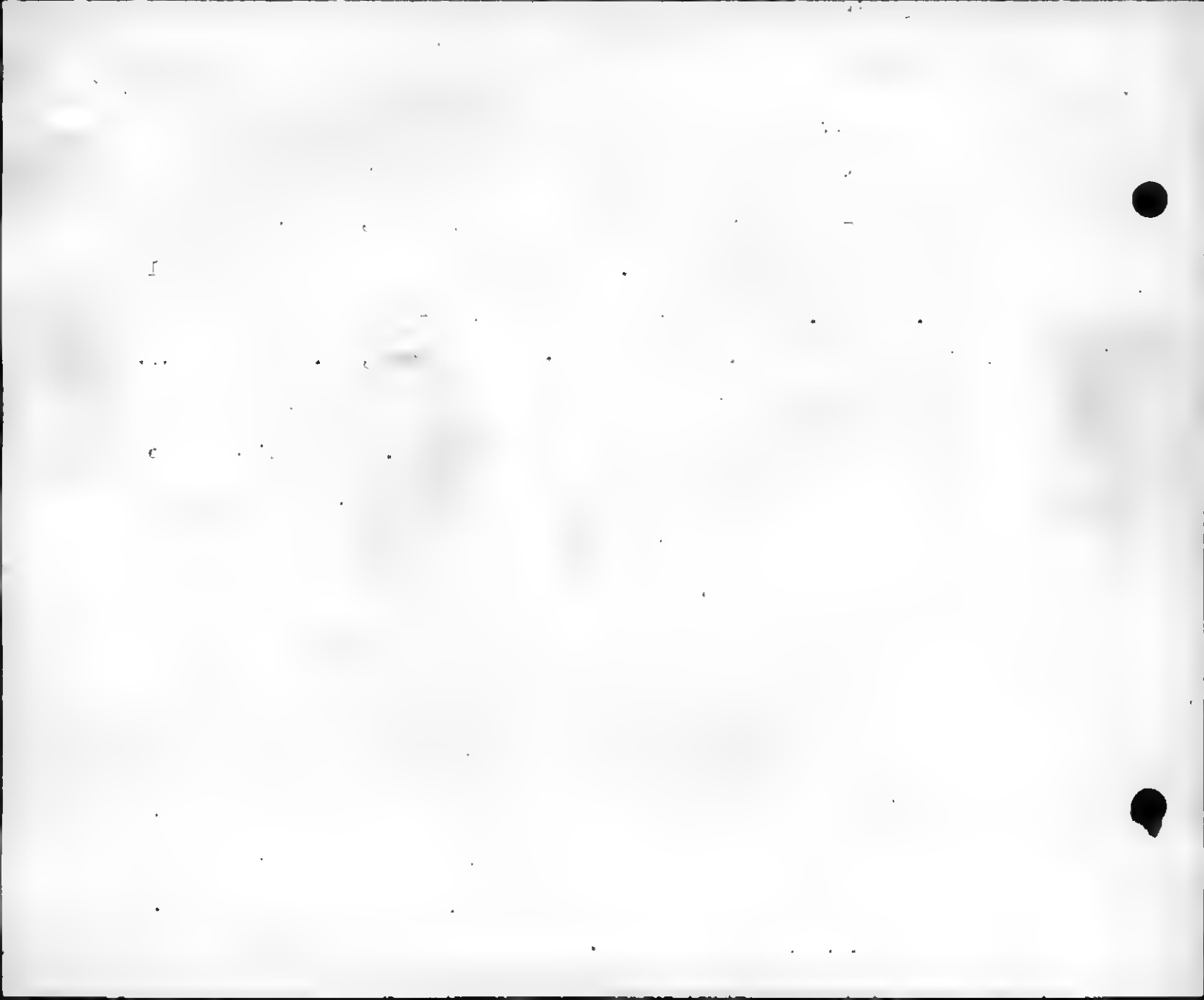
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01845
CERTIFICATE OF DEATH
01841

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN ID 2/10/67 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shangri-La Nursing Center		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 1104 Glen Hunt Road c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland d. STREET ADDRESS Baltimore, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian T. Jones First Middle Last		4. DATE OF DEATH Feb 18 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/1897
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothes Fitter (Ret.)		10b. INDUSTRY OF BUSINESS OR INDUSTRY Hutzler Bros.	
11. BIRTHPLACE (County & State, or foreign country) Pulaski, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Rayburn Taylor		14. MOTHER'S MAIDEN NAME Margaret Ritter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 230-10-5606	
17. INFORMANT Samuel P. Jones		Address 8319 Wyton Road 4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration + Malnutrition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Scurdices + Chronic diarrhea DUE TO (c) Carcinoma of Pancrease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1966 , to Feb. 1967 , that (I) (we) last saw the deceased alive on Feb. 25 1967 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE William J Bryson		22b. DATE SIGNED 26 Feb-67	
22c. PHYSICIAN'S NAME (Type) William J BRYSON		22d. ADDRESS 4605 Edmondson Ave Balto 29 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-1-67	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzke F.D.		25a. REC'D BY REGISTRAR FEB 28 1967	
ADDRESS 4101 Edmondson Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



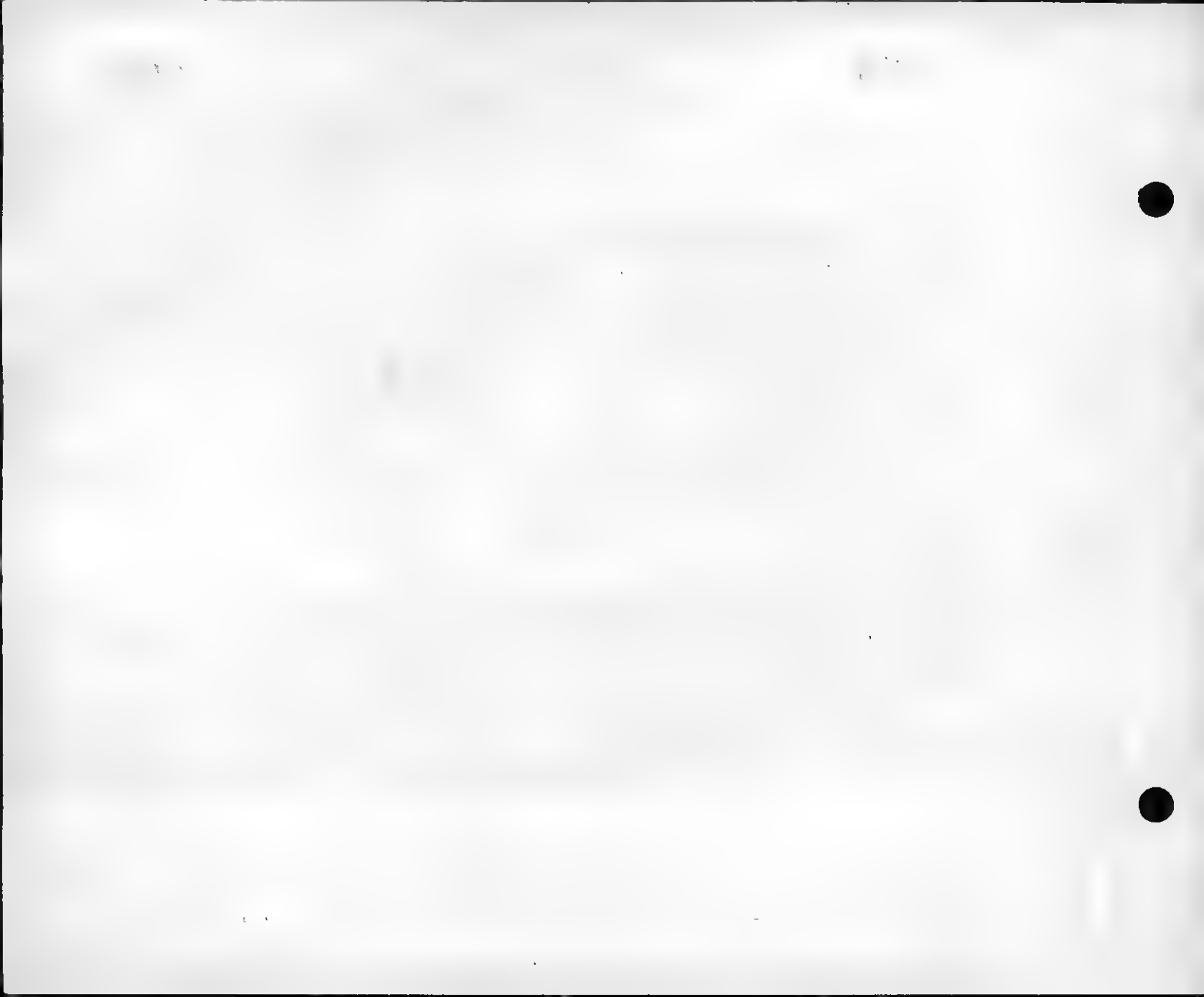
01846

CERTIFICATE OF DEATH

01842

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Res dence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roseville</u>		c. LENGTH OF STAY IN Tb <u>Two Weeks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>5909 Edmondson Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Gilbert</u> First <u>Jordan</u> Middle <u>Jordan</u> Last		4. DATE OF DEATH Month <u>2</u> - Day <u>11</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-87</u>
9. AGE (n years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Meat Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Celix</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>87-07-1779</u>	
17. INFORMANT <u>Paul Jordan - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 510X DUE TO (b) <u>Massive Pulmonary Congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Post. Operative (1-30-67) Intestinal Resection of gangrenous 2 feet of ileum</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-29</u> , 19 <u>67</u> , to <u>2-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-11</u> , 19 <u>67</u> , and that death occurred at <u>7 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Albert S. Barretto</u>		22b. DATE SIGNED <u>2-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERTO S. BARRETTO</u>		22d. ADDRESS <u>Balto. Cty. Gen. Hosp., det Ct. Rd., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-15-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Somerton, Pennsylvania</u>
24. FUNERAL DIRECTOR <u>Ellsworth Chace</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>	
4600 Liberty Hghts. Avenue		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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1

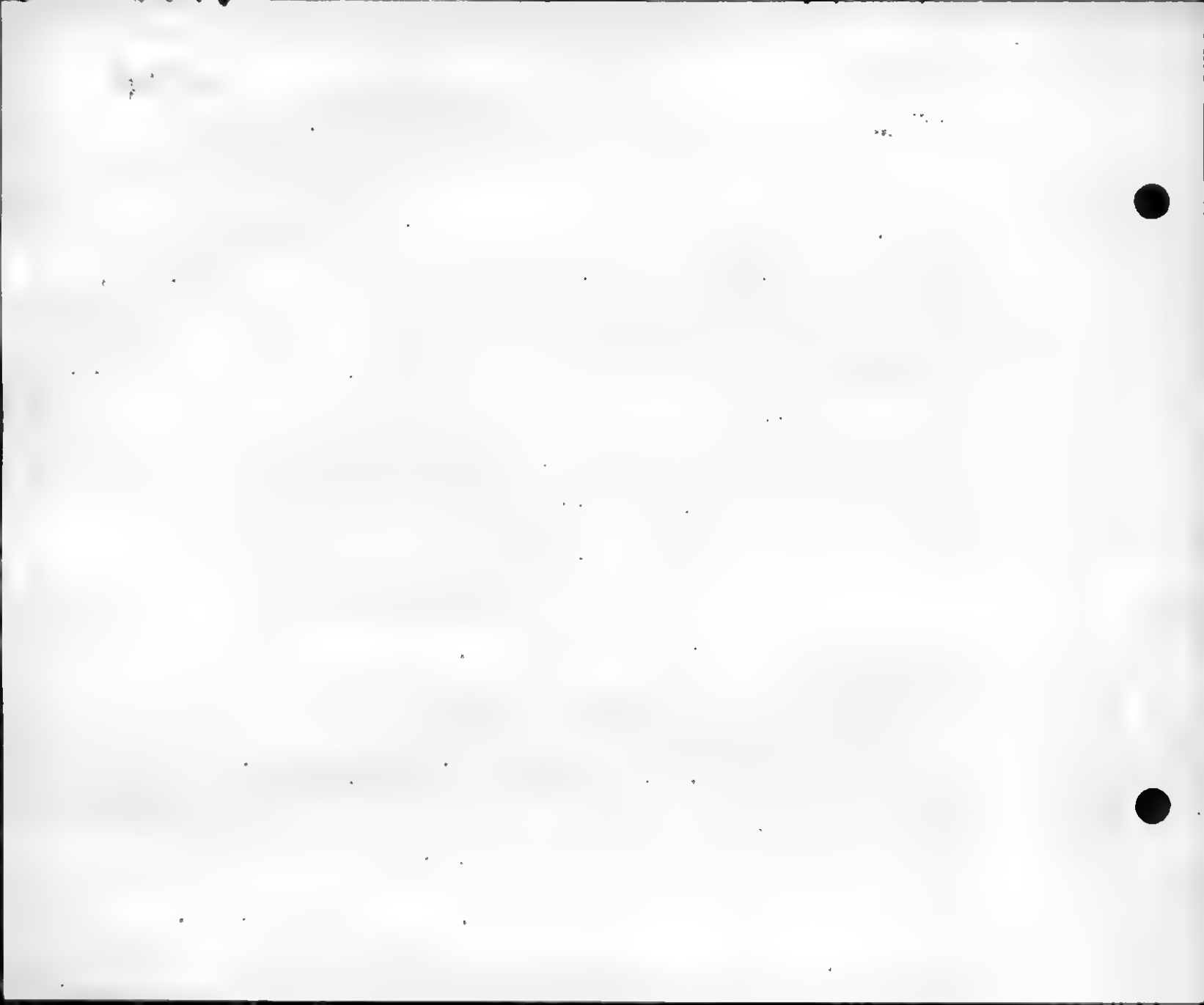
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01847

CERTIFICATE OF DEATH

01843

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c LENGTH OF STAY in 1b 2 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206		
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 13 E. Overlea Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Anna Middle M. Last Kaltenbach				4 DATE OF DEATH Month Feb. Day 20 Year 19 67			
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 AGE (In years last birthday) yrs 73	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian Richter				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-09-3246d		17. INFORMANT Address Christian Richter 17 E Overlea Ave 21206			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction, left ventricle. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Thrombosis right coronary artery. DUE TO (c) Arteriosclerosis generalized severe.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Multiple pulmonary infarctions, right lung.							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from Feb. 18 , 19 67 , to Feb. 20 , 1967, that X (we) last saw the deceased alive on Feb. 20 , 1967, and that death occurred at 4:50 p.m. from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED February 21, 1967	
22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.				22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/23/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24 FUNERAL DIRECTOR <i>[Signature]</i>				ADDRESS 7401 Belair Road		25a. REC'D BY REGISTRAR MAR 1 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							



1

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01848

01844

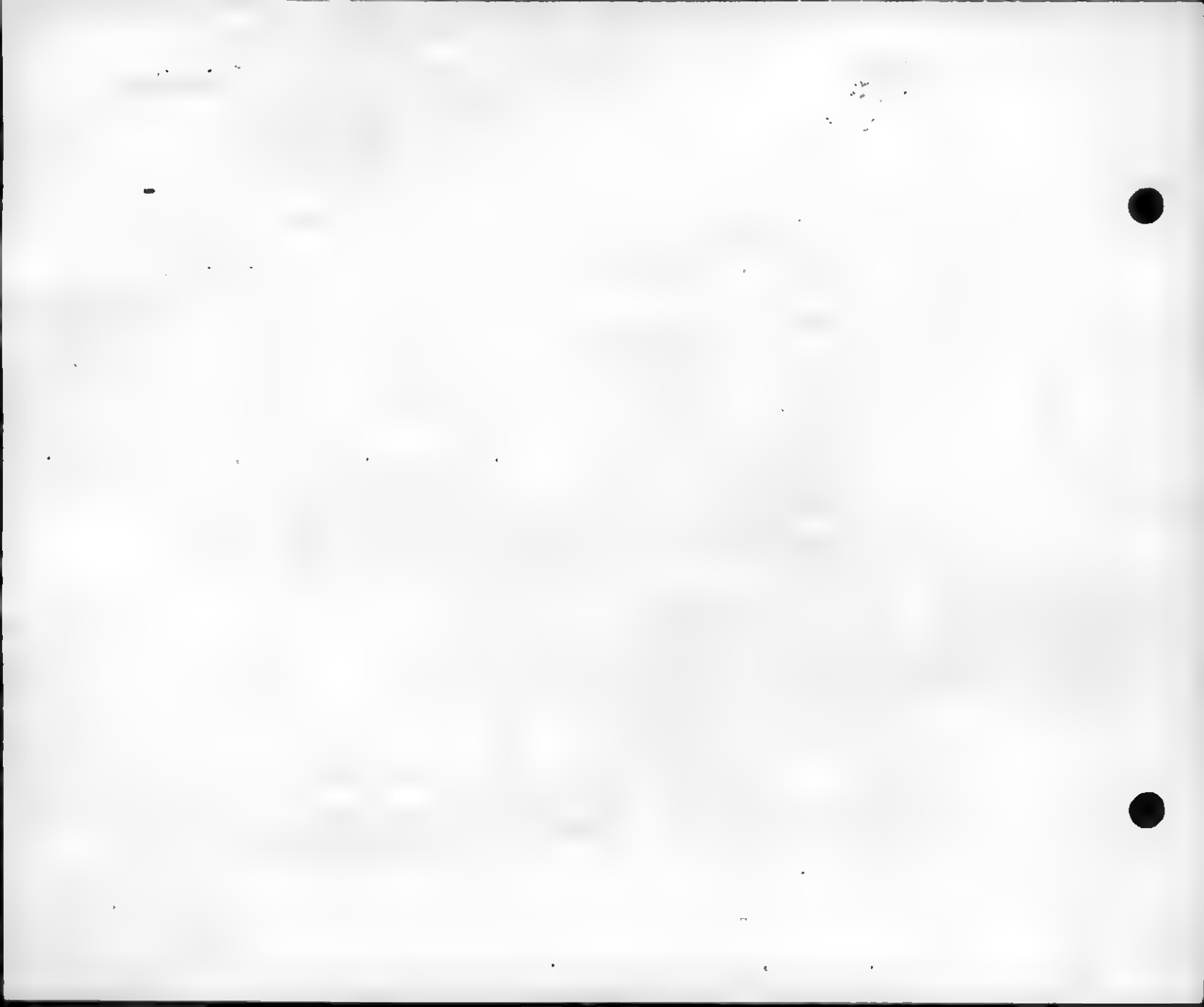
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) a. STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c LENGTH OF STAY IN b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Paradise Nursing Home		d STREET ADDRESS 5009 Leeds Avenue	
3 NAME OF DECEASED (Type or print) MARY A. KASINSKAS		4 DATE OF DEATH February 7, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-24-1884
9 AGE (In years last birthday) 83 yrs.		10 IF UNDER 1 YEAR Months Days Hours Min.	
11b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Lithuania		12 CITIZEN OF WHAT COUNTRY? Lithuania	
13. FATHER'S NAME Joseph Saukatis		14. MOTHER'S MAIDEN NAME Catherine Motckevic	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT Mr. William L. Kasinskas, 5009 Leeds Ave.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Congestive G.S.P. D. DUE TO (c) (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1945 to 1966 , that (I) (we) last saw the deceased alive on Feb. 7, 1967 , and that death occurred at 12:32 AM , from causes and on the date stated above.			
22a SIGNATURE Dr. Stanley Ankudas		22b DATE SIGNED 2.8.67	
22c PHYSICIAN'S NAME (Type) Dr. Stanley Ankudas		22d ADDRESS 1101 Maiden Choice Lane	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 2-10-1967	23c NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a REC'D BY REGISTRAR FEB 10 1967	
25b REGISTRAR'S SIGNATURE Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

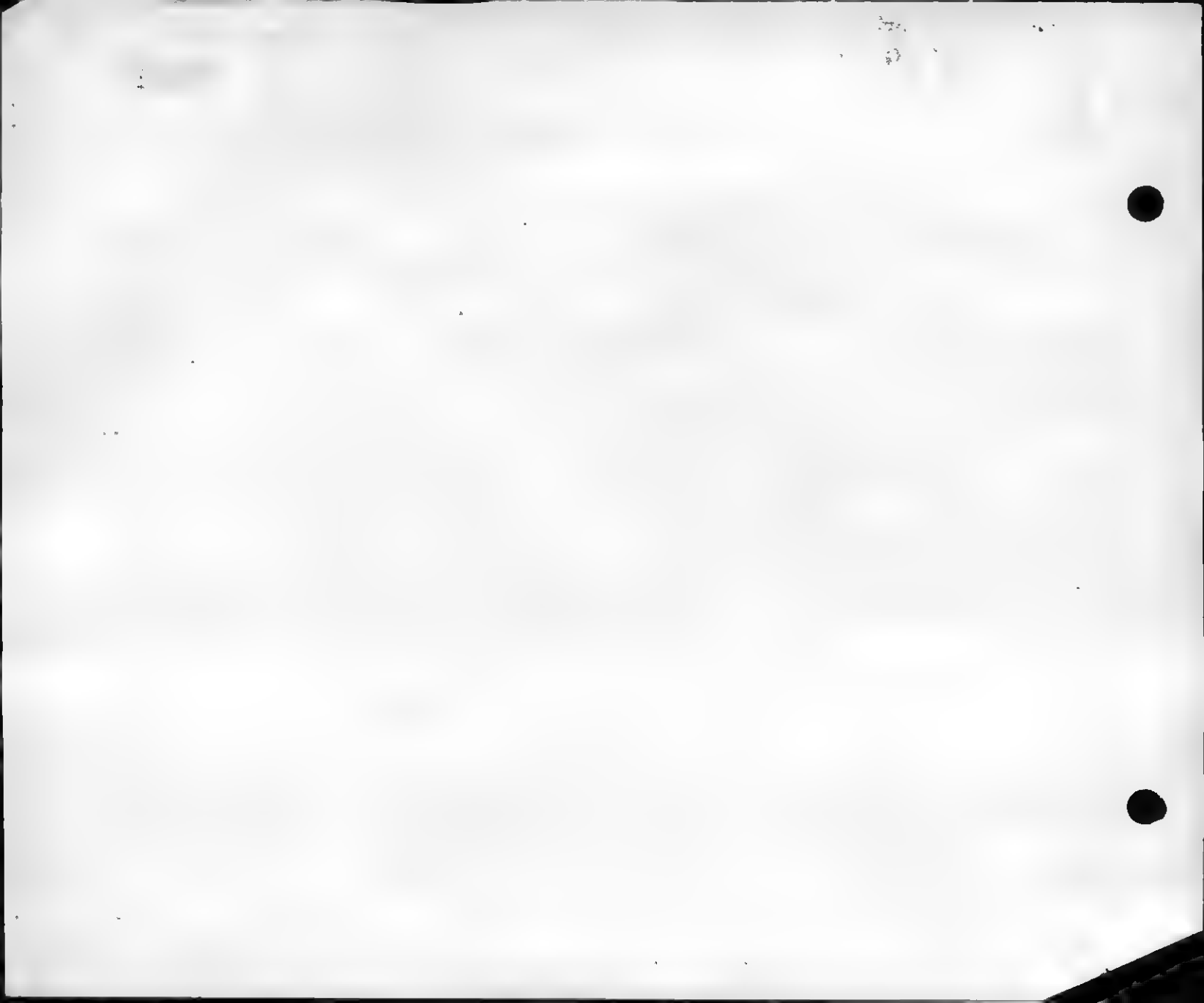
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01849					01845					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY		BALTIMORE			a. STATE		Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MARYLAND			b. COUNTY		City of Balto.			
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		City of Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Armacost Nursing Home - Regester Av.					3802 Fenchurch Road					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		Month Day Year			
MADISON BLATCHFORD KAYSER					Feb. 26, 1967		19			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb. 7, 1901		66 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
NONE					NONE		Bedford Co., Pa.		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
John K. Blatchford					Anna Jenkins					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT : husband Address			
NO					NONE		Balto., 21218			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>1st</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-Sclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cirrhosis of Liver</i>					INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 19</i> , 1967, to <i>Feb 26</i> , 1967, that (I) (we) last saw the deceased alive on <i>Feb 19</i> , 1967, and that death occurred at <i>12:45</i> M, from the causes and on the date stated above.										
22a. SIGNATURE <i>Thedon Inthout</i>					22b. DATE SIGNED <i>2/28/67</i>					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
BURIAL					3/1/1967		Druid Ridge		Pikesville, Balto. Co., Md.	
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Stewart & Loven Co. 108 N. North Av., Balto.					21201		DATE MAR 1 1967		<i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01850

CERTIFICATE OF DEATH

01846

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY in 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERA BEACH		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 233 MEADOW ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last JAMES FRANCIS KEARNEY				4 DATE OF DEATH Month Day Year FEBRUARY 27 19 67			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH OCTOBER 3, 1895		9 AGE (in years last birthday) yrs. 71	f. UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR		10b. KIND OF BUSINESS OR IND. STRY STEEL		11 BIRTHPLACE (County & State, or foreign country) IRELAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS KEARNEY				14. MOTHER'S MAIDEN NAME MARY FLYNN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16 SOCIAL SECURITY NO 207 05 30 49		17 INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 71A PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN DEATH AND DEATH 3
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF PROSTATE							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEB. 26 , 19 67 , to FEB 27 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEB 27 , 19 67 , and that death occurred at 930P M, from causes and on the date stated above							
22a SIGNATURE <i>Howard C. Kramer</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/28/67	
22c. PHYSICIAN'S NAME (Type) HOWARD C. KRAMER, M.D.				22d. ADDRESS VA Hospital, Fort Howard, Md.			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 3, 1967		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR George J. Gonce Gonce Funeral Home				ADDRESS 4001 Gov Ritchie Hwy Balto, Md.		25 REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body.

VR A15 (4)
20 M 1/66

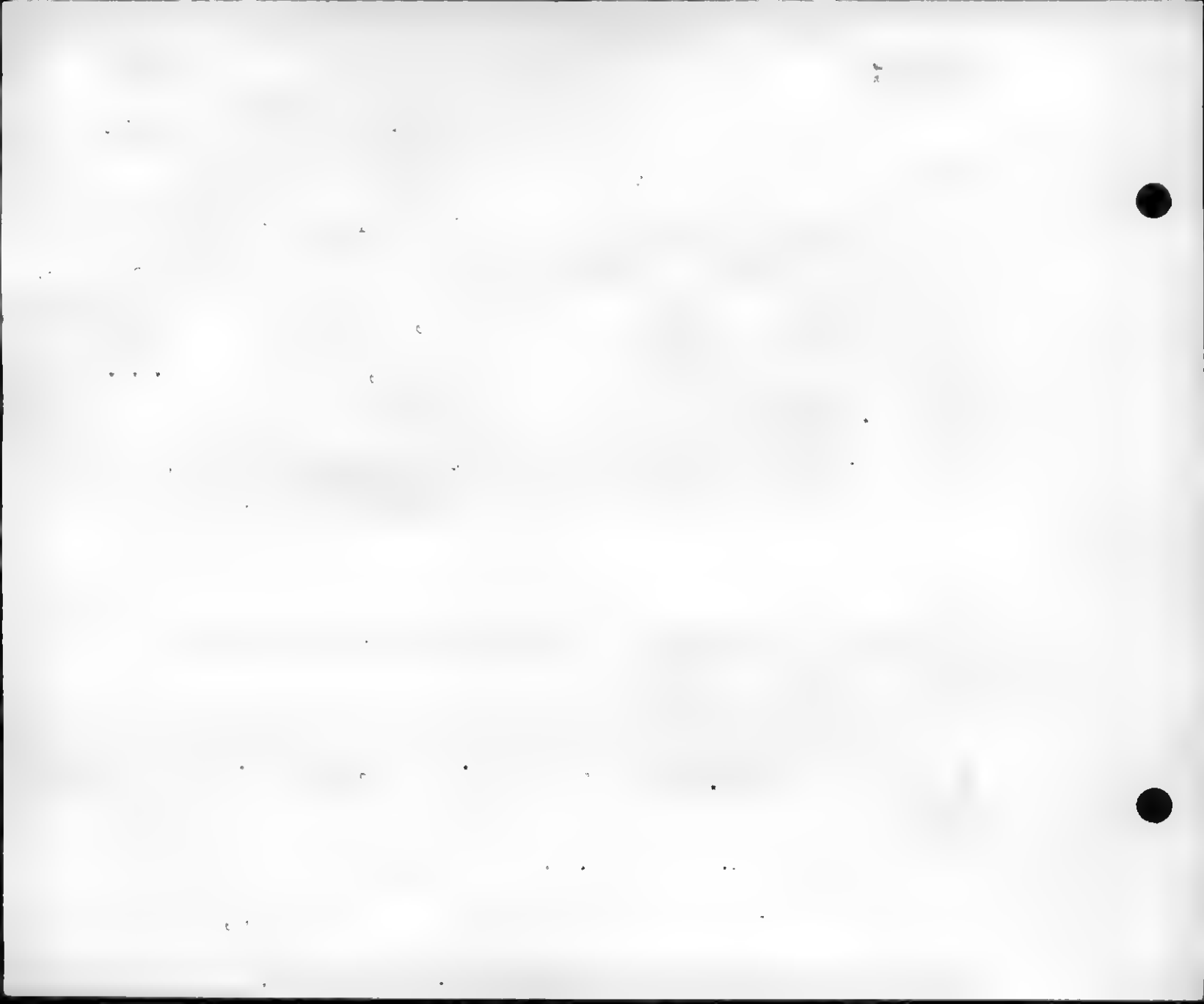
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01851

CERTIFICATE OF DEATH

01847

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3210 WEST BALTIMORE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD EIMHORST KELLEY				4. DATE OF DEATH Month Day Year FEBRUARY 13 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 31, 1918	9. AGE (In years last birthday) 48 yrs.	if UNDER 1 YEAR Months Days		if UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD J. KELLEY				14. MOTHER'S MAIDEN NAME ROSALEE EIMHORST			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO 216 01 62 71		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PULMONARY EDEMA AND CONGESTION OF RIGHT LUNG						INTERVAL BETWEEN ONSET AND DEATH DAYS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) THROMBOSIS OF ABDOMINAL AORTA WITH OCCLUSION OF COMMON ILIAC ARTERIES						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEB. 12 , 19 67 , to FEB. 13 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEB. 13 , 19 67 , and that death occurred at 1245A , from causes and on the date stated above.							
22a. SIGNATURE <i>Sheldon E. Kaimutz</i>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/13/67	
22c. PHYSICIAN'S NAME (Type) SHELDON E. KAIMUTZ, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-15-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR WITZKE FUNERAL HOME 4101 EDMONDSON AVE. BALTIMORE, MD.				25a. REC'D BY REGISTRAR DATE FEB 15 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

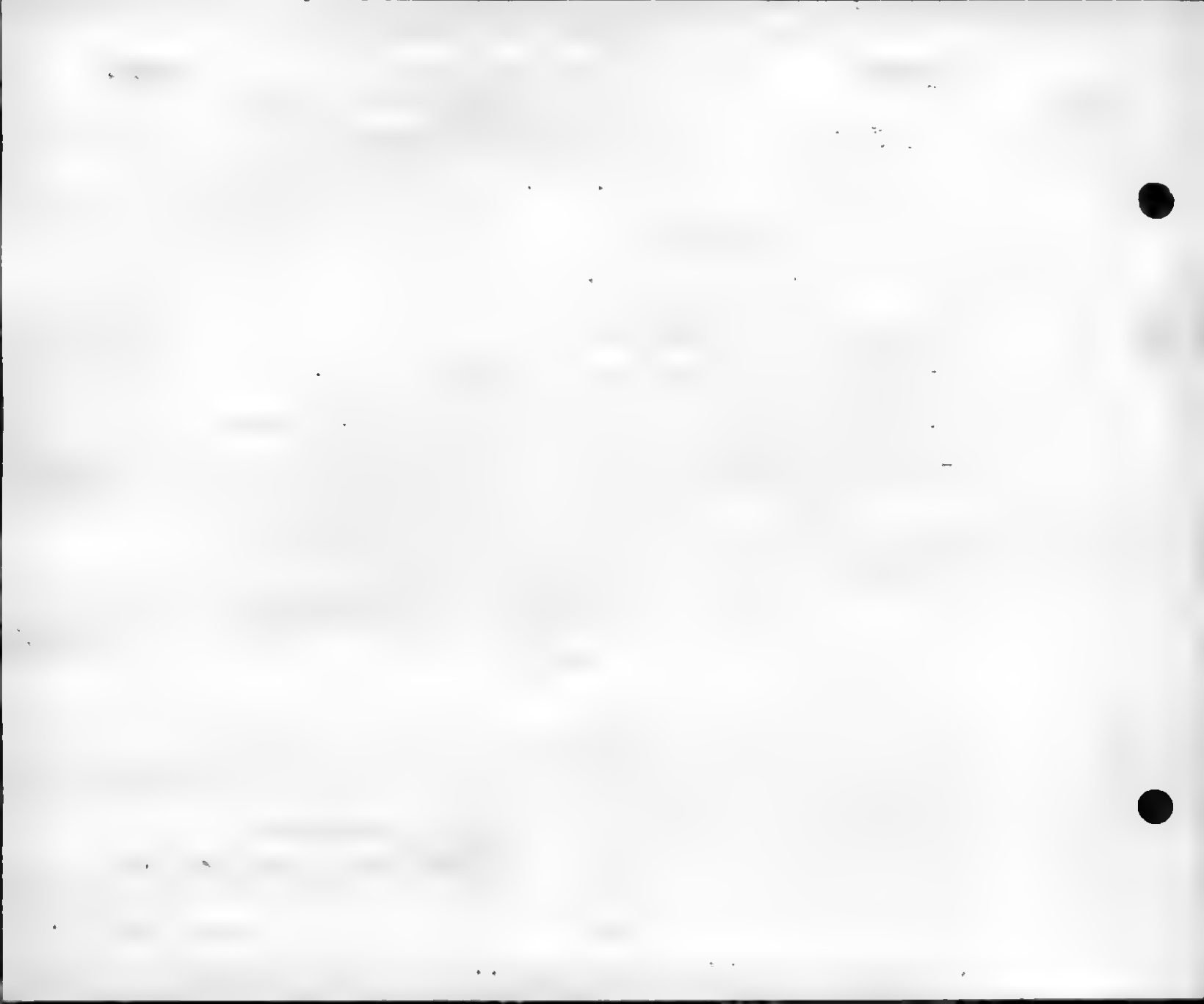
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01852

CERTIFICATE OF DEATH

01848

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN 1b <u>App. 7 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Hospital</u>		d. STREET ADDRESS <u>1500 Lakeside Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jerome G. Kelly Jr.</u>		4. DATE OF DEATH Month Day Year <u>February 28 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-65</u>
9. AGE (In years last birthday) <u>1</u> yrs		10. F UNDER 1 YEAR Months Days Hours Min	
10a. USUA. OCCUPAT ON (Give kind of work done during most of working life, even if retired) <u>--</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. Jerome G. Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Mauldin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO <u>--</u>	
17. INFORMANT <u>Rosewood State Hospital Medical Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection - site undetermined</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFIKANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Microcephaly; severe mental retardation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from _____, 19____, to <u>2-12-67</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>2-12-67</u> , 19____, and that death occurred at <u>4:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Zieve</u>		22b. DATE SIGNED <u>2/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Zieve</u>		22d. ADDRESS <u>ROSEWOOD STATE HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-3-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		25a. REC'D BY REGISTRAR <u>2 MAR 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			



VR A15 (4)
20 M 1/66

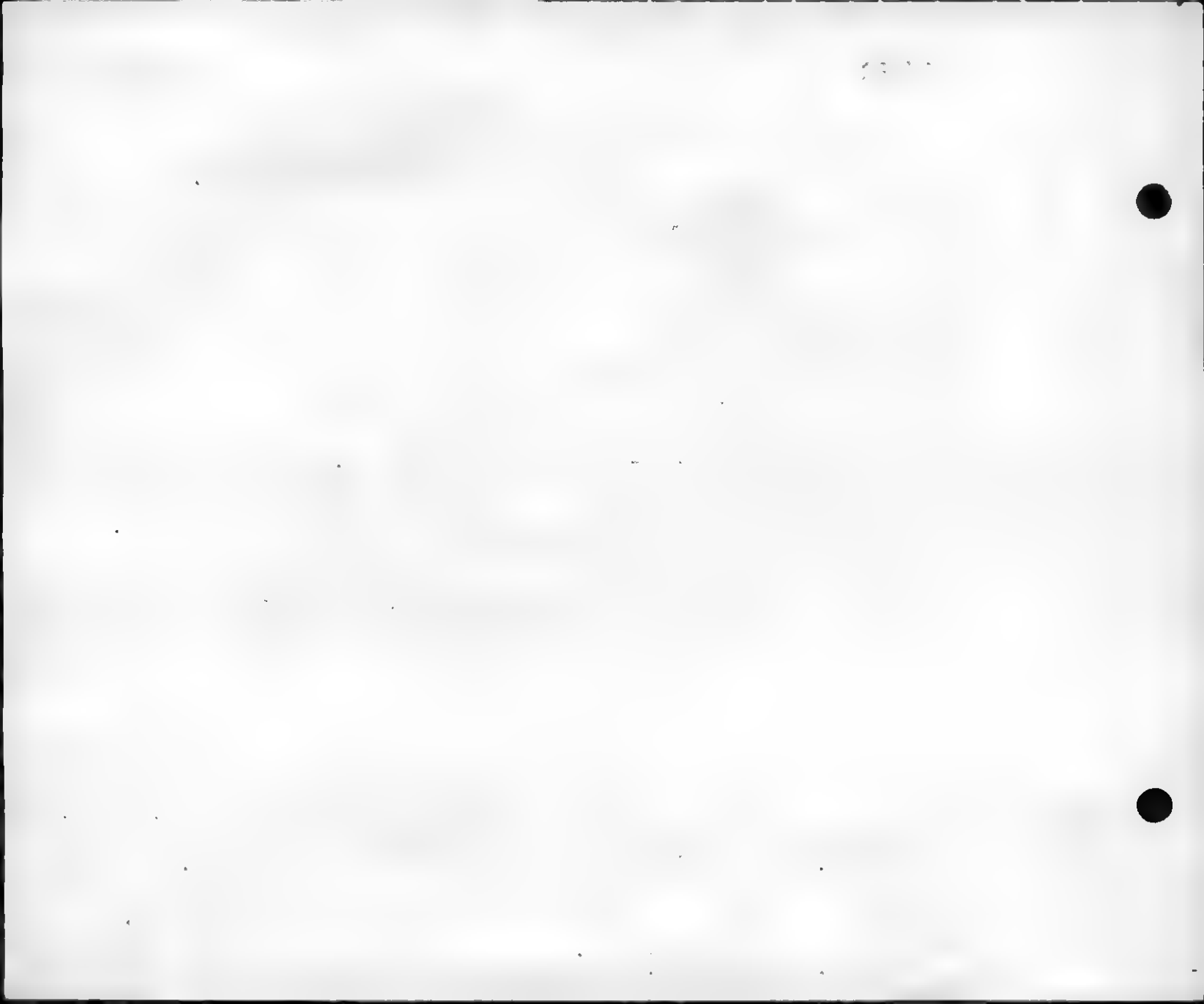
2

Item 2 File G366 3/6/67 mh

CERTIFICATE OF DEATH

01849

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Idlewild		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) /812/ Register St./ Baltimore		d. STREET ADDRESS 2516 E. Madison St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armecost Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First Middle Last KLECKA		4. DATE OF DEATH February 18 19 67		Month Day Year	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/5/77	
9. AGE (In years last birthday) 89		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (County & State, or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Slechta				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO 215-22-4782		17. INFORMANT Mildred Pretl, neice, 2109 Woodburn Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Localizing arterial disease both brain DUE TO Arteriosclerosis DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) genl arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 17 , 19 67 to Feb 18 , 19 67 , that (I) (we) last saw the deceased alive on Feb 17 , 19 67 , and that death occurred at 1:00 PM , from causes and on the date stated above.							
22a. SIGNATURE Dr. Donald Mintzer		22b. DATE SIGNED Feb 20 1967		22c. PHYSICIAN'S NAME (Type) Dr. Donald Mintzer			
22d. ADDRESS 3009 Evergreen Ave.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/67		23c. NAME OF CEMETERY OR CREMATORY Bohemian National Cem		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25a. REC'D BY REGISTRAR FEB 23 1967		25b. REGISTRAR'S SIGNATURE James J. Judge			
2601 E. Madison St.							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

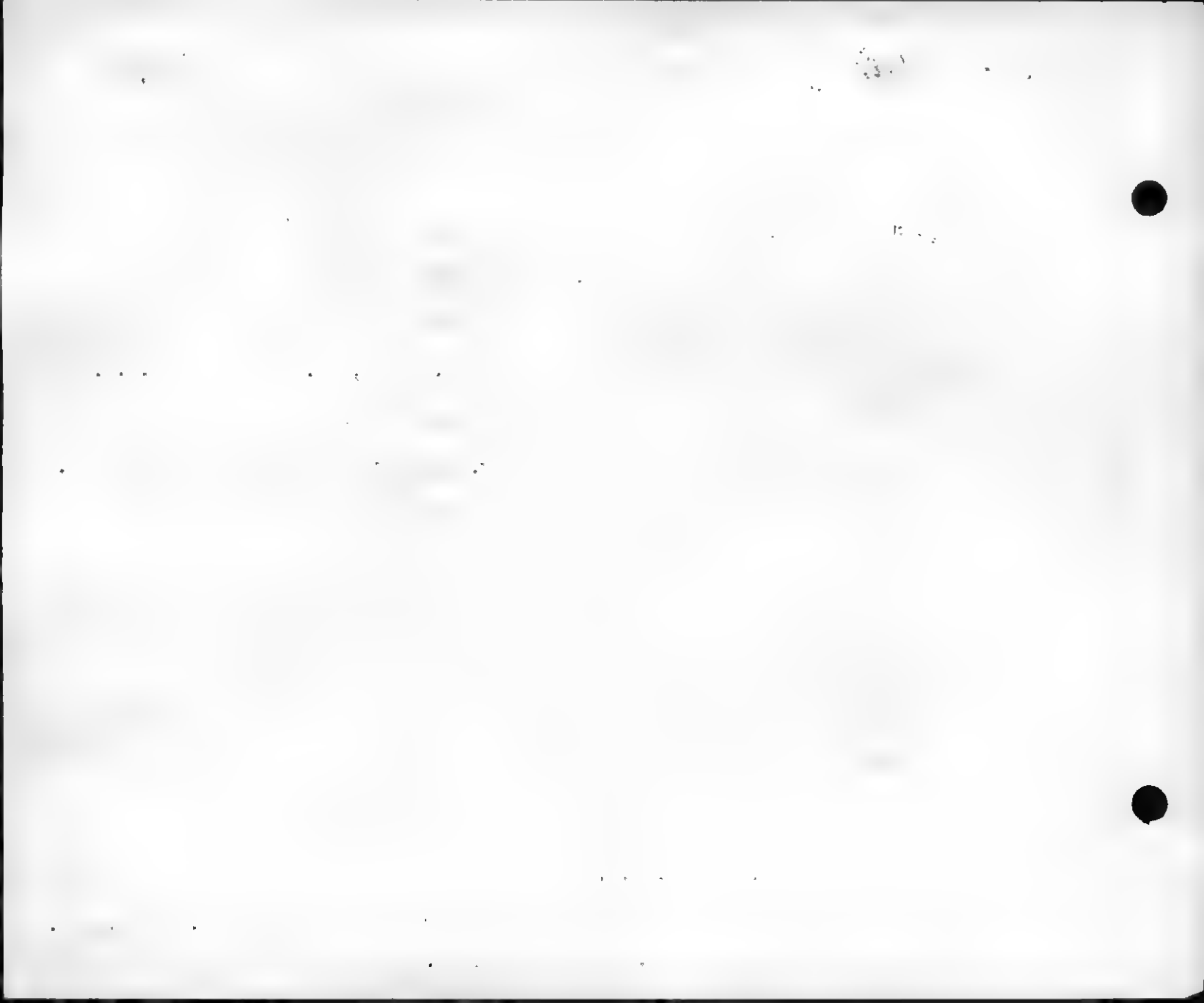
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01854

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01850

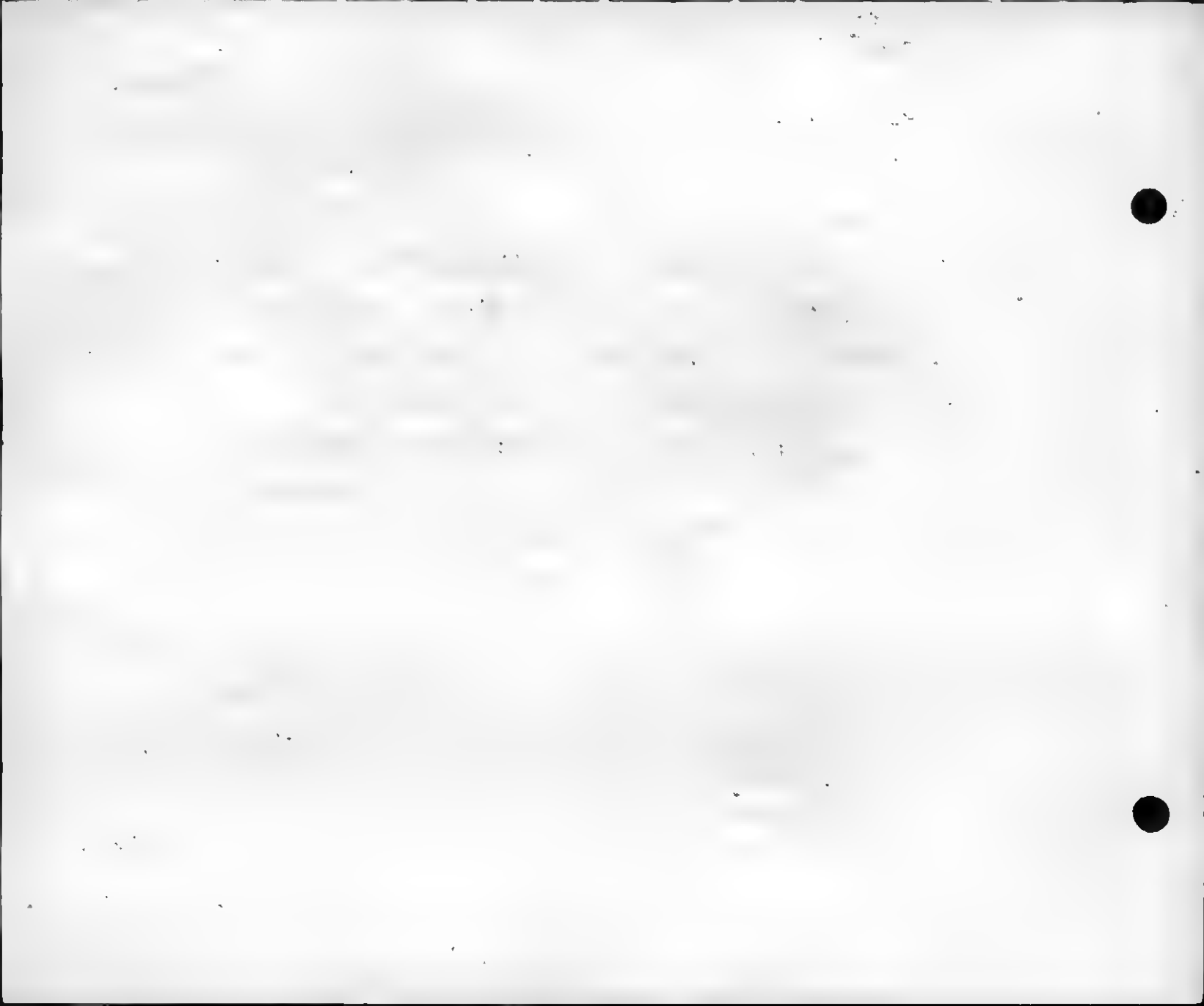
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General Hospital				e. STREET ADDRESS 7017 Queen Anne's Road			
3. NAME OF DECEASED (Type or print) First BARRY Middle L. Last KLINE				4. DATE OF DEATH Month 2 Day 28 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/1949		9. AGE (In years last birthday) yrs 18	10. IF UNDER 1 YEAR Months 18 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rev. Theodore Kline				14. MOTHER'S MAIDEN NAME Beulah Deal			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO None		17. INFORMANT Rev. Theodore Kline-7017 Queen Anne Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Idiopathic cardiomyopathy 4544 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2/3/67		23c. NAME OF CEMETERY OR CREMATORY Moreland Cemetery		23d. LOCATION (City or town) (County) (State) Taylor Ave. Balt. Md.	
24. FUNERAL DIRECTOR Loring Byers-3728 Liberty Rd. Randallstown, Md.				25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OVERLEA c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7014 BEECH AVE						2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MD b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OVERLEA d. STREET ADDRESS 7014 BEECH AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CHRISTOPHER J. KLINGENBERG						4. DATE OF DEATH Feb. 1 1967					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV 27 1896		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE MANAGER K.C.				10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ADAM KLINGENBERG						14. MOTHER'S MAIDEN NAME ANNA ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WORLD WAR I				16. SOCIAL SECURITY NO. 722-09-3194		17. INFORMANT MARGARET J. KLINGENBERG 7014 BEECH AVE Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion x011 DUE TO (b) hypertensive arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) hypertensive arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 19 1967 to Feb 1 1967 , that (I) (we) last saw the deceased alive on Jan 19 1967 , and that death occurred at 6 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Richard P. Rigler						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) RICHARD P. RIGLER						22d. ADDRESS 1. W. Overlea Club & BALTO 6					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 2/4/67		23c. NAME OF CEMETERY OR CREMATORY PARK WOOD			23d. LOCATION (City, town or county) (State) TAYLOR H/E BALTO. MD			
24. FUNERAL DIRECTOR DIPPEL BROS INC 7110 BELAIR RD						25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			

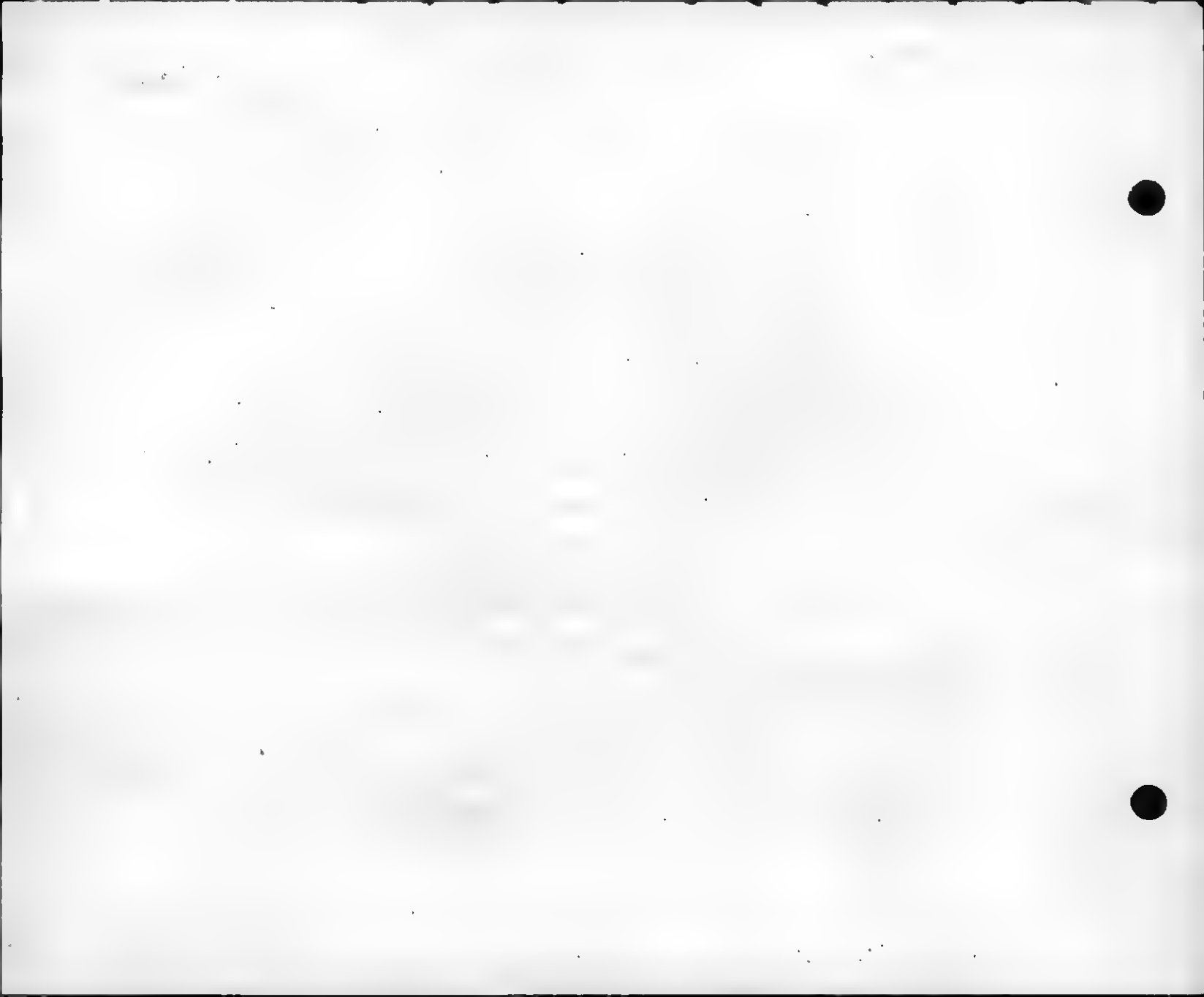


TO MULTIPLE ON ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01856 CERTIFICATE OF DEATH 01852

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>	
c. LENGTH OF STAY IN ID <u>4 yrs</u>		d. STREET ADDRESS <u>5744 First Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5744 First Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carroll R. Koehler</u>		4. DATE OF DEATH <u>February 1</u> 19 <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/1/17</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Technologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dental</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Koehler</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Reichert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>W. W. II</u>		16. SOCIAL SECURITY NO. <u>217-51-6395</u>	
17. INFORMANT <u>Mabel R. Koehler</u>		Address <u>5744 First Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia due to chronic</u> <u>glomerular nephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>glomerular nephritis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov.</u> , 19 <u>66</u> , to <u>Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1 Feb</u> 19 <u>67</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William J. Bryson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>William J. Bryson</u>		22d. ADDRESS <u>4605 Edmondson Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Andrew J. 1328 Salgham Spring Rd.</u>		25a. REC'D BY REGISTRAR <u>Feb 6</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

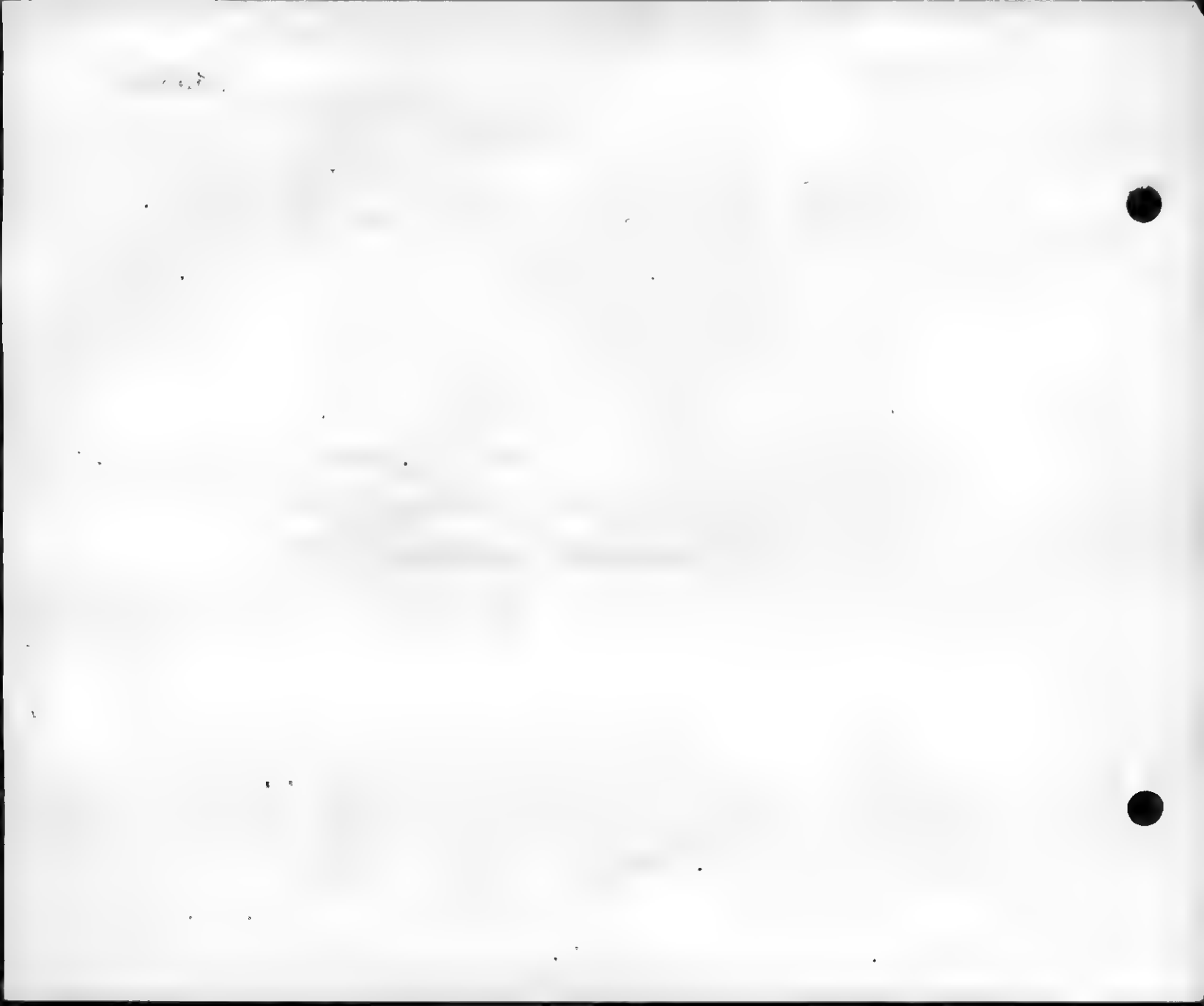
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01857

01853

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE / Baltimore 21227	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES NURSING HOME		d. STREET ADDRESS 16 EUSTING AVE.	
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMORY Middle H. Last KOHLHAUS		4. DATE OF DEATH Month FEB. Day 16 Year 19 67	
5. SEX MALE MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/91
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (Country & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES E. KOHLHAUS		14. MOTHER'S MAIDEN NAME MINNIE E. HIGH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 212 05 5531	
17. INFORMANT CHARLES E. KOHLHAUS		Address 5537 OREGON AVE. 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular hemorrhage, recurrent DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hypertensive arteriosclerotic C V D DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A TOLPS PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/28/1967 to 2/16 , 19 67 , that (I) (we) last saw the deceased alive on 2/15 , 19 67 , and that death occurred at 2:10 P.M. causes and on the date stated above.			
22a. SIGNATURE <i>Herbert J. Levickas</i> M.D.		22b. DATE SIGNED 2/17/67	
22c. PHYSICIAN'S NAME (Type) HERBERT J. LEVICKAS		22d. ADDRESS 1073 MAIDEN CHOICE LAND 21229	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/20/67	23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY	23d. LOCATION (City or town) (County) (State) BALTO., MD.
24. FUNERAL DIRECTOR HOWARD H. HUBBARD		ADDRESS 4107 WILKENS AVE. 21229	
25a. REC'D BY REG. STRAR DATE FEB 20 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

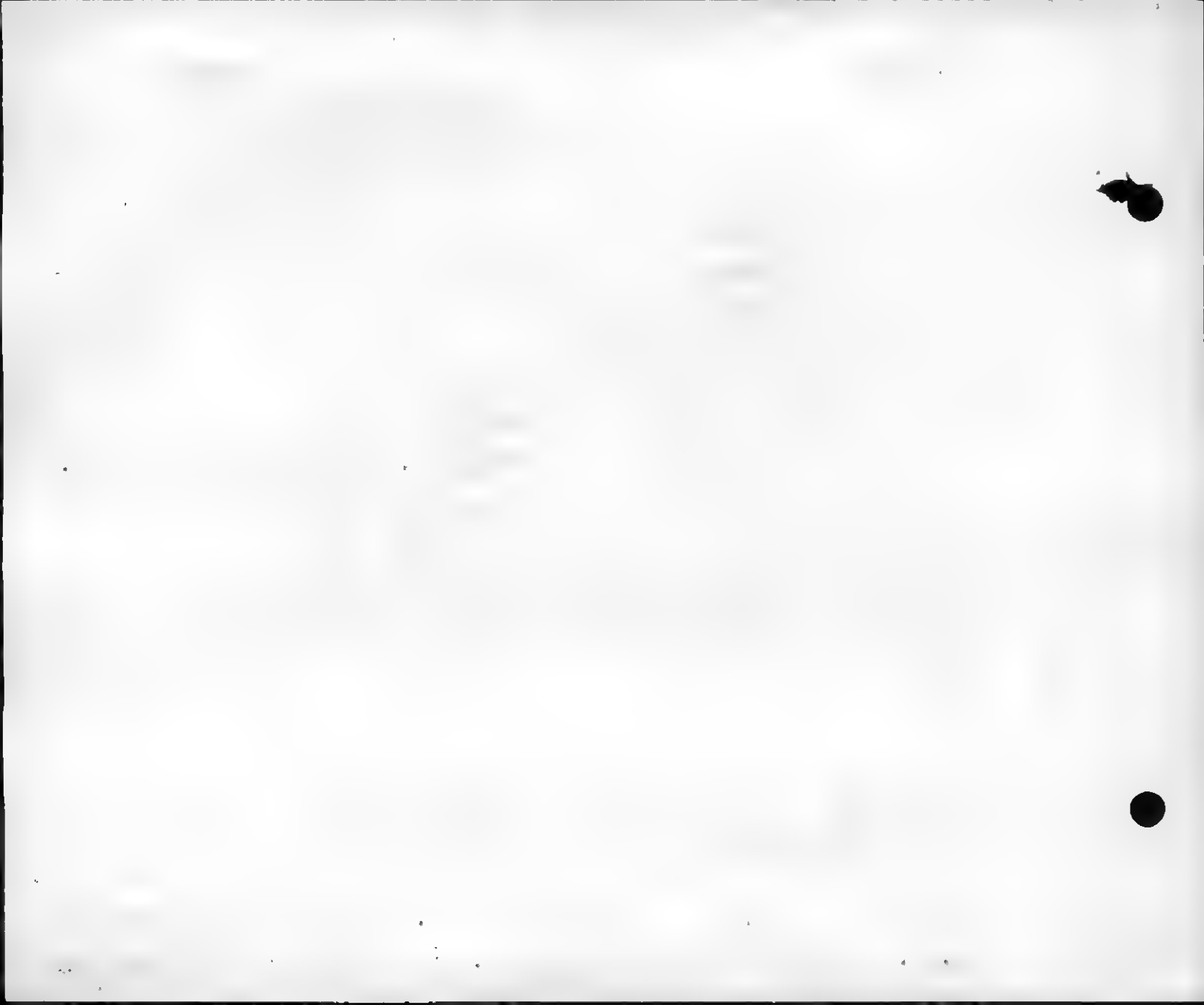
01858

CERTIFICATE OF DEATH

01851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>24 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE Medical Center</u>		d. STREET ADDRESS <u>1819 Cromwood Road</u>	
3 NAME OF DECEASED (Type or Print) <u>HAZEL</u> First <u>M.</u> Middle <u>Kratz</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-10-88</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9 AGE (in years last birthday) <u>78</u> yrs
11 BIRTHPLACE (County & State or foreign country) <u>VIRGINIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John Rolfe</u>		14 MOTHER'S MAIDEN NAME <u>Marion Temple</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Charles I. Kratz</u>		Address <u>1819 Cromwood Rd.</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF CERVIX AND LUNG</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-23</u> , 1967, to <u>2-24</u> , 1967, that (I) (we) last saw the deceased alive on <u>2-24</u> , 1967, and that death occurred at <u>3:45 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Mario B. Ines</u>		22b DATE SIGNED <u>2-24-67</u>	
22c PHYSICIAN'S NAME (Type) <u>MARIO B. INES M.D.</u>		22d ADDRESS	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>2/27/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>Wm. E. Johnson</u>		25a REC'D BY REGISTRAR <u>Charles Jones</u>	
ADDRESS <u>8521 Loch Raven Blvd.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Jones</u>	
DATE <u>FEB 28 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01859

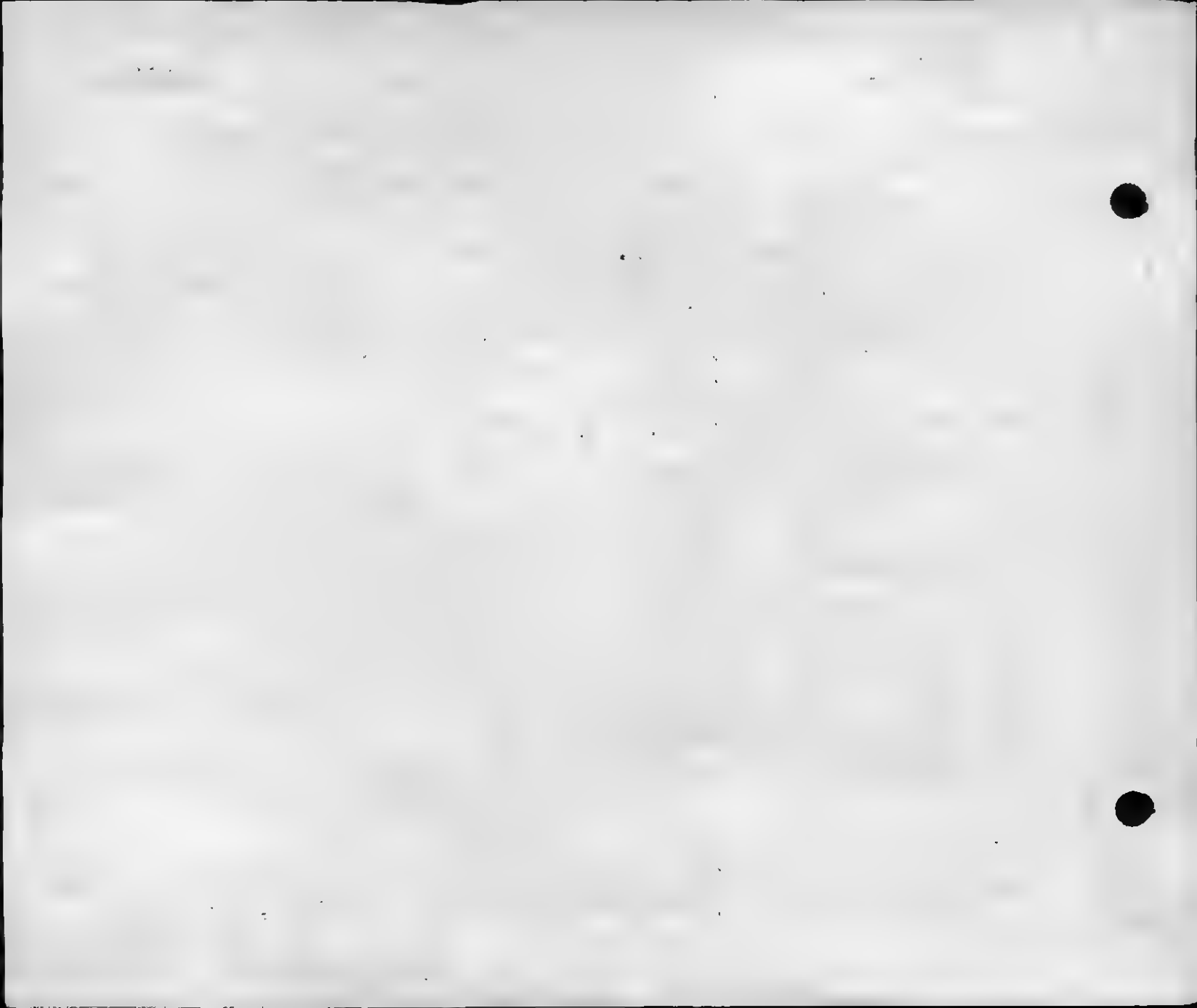
CERTIFICATE OF DEATH

01855

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, read as before admission) e. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Forest Haven Nursing Home		d. STREET ADDRESS 8138 Loch Raven Blvd	
3. NAME OF DECEASED (Type or print) First Margaret Middle M. Last Larkin		4. DATE OF DEATH Month February Day 27, Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 16, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ?	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LUTHER GERRICK		14. MOTHER'S MAIDEN NAME MARY KELLY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Forrest Haven Nursing Home		Address Forest Haven Nursing Home	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe debilitation DUE TO (b) Carcinoma of bowel DUE TO (c) arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 2-4 yrs 2-4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Nov. 16, 1967 to Feb. 27, 1967 , that (we) last saw the deceased alive on Feb. 27, 1967 , and that death occurred at 3:15 AM , from the causes and on the date stated above			
22a. SIGNATURE John J. Conroy, M.D.		22b. DATE SIGNED 2/27/67	
22c. PHYSICIAN'S NAME (Type) John J. Conroy, M.D.		22d. ADDRESS 5800 Edmonson Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/2/1967	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town or county) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Richardson		25. REC'D BY REGISTRAR FEB 28 1967	
25b. REGISTRAR'S SIGNATURE William J. Richardson		25c. ADDRESS Baltimore, Md.	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
15M



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01860

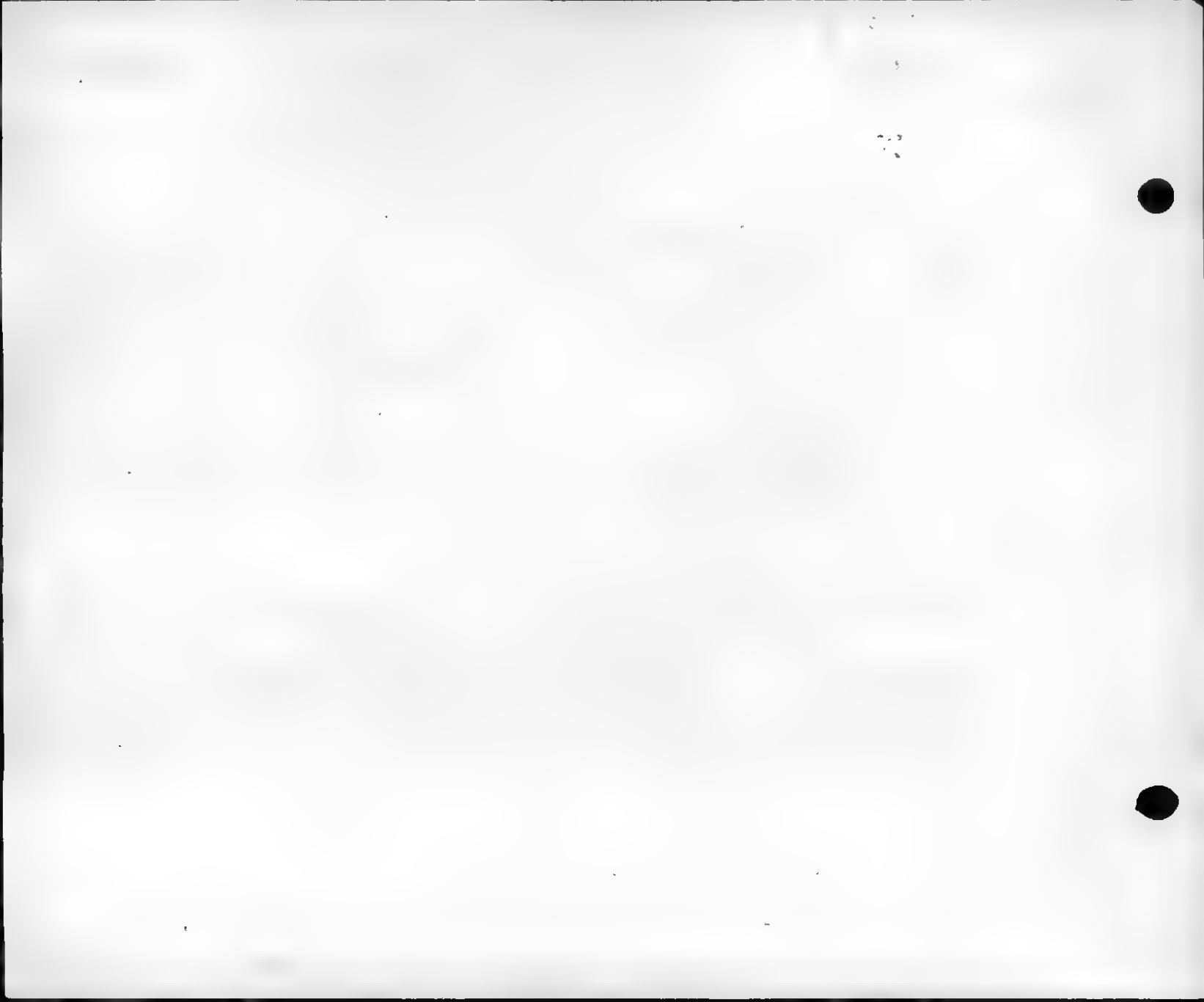
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01856

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the examiner should execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville 8		c. LENGTH OF STAY IN 1b Finksburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Milford Mill Rd.		d. STREET ADDRESS Box 410- Deer Park Rd.	
3. NAME OF DECEASED (Type or print) First Charles Middle Alexander Last Lau		4. DATE OF DEATH Month Feb. Day 15 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1934
9. AGE (In years lost birthday) 32 yrs.		10. IF UNDER 1 YEAR Months 32 Days 32 Hours 32 Min 32	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Harry Lau		14. MOTHER'S MAIDEN NAME Ruth Eaton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 215-30-0715	
17. INFORMANT Mrs. Dorothy Lau, Rocklyn & Milford Mill Rd. Pikesville 8		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound left side of neck & face DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased shot himself with a 12 gauge shotgun.	
20c. TIME OF INJURY Month, Day, Year 9:52 p.m. Feb. 15 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) pay phone booth	20f. (City or town) (County) (State) Pikesville Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		22. DATE SIGNED 2-17-67	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-18-1967	23c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery Westminster, Maryland	23d. LOCATION (City or Town) (County) (State)
24a. FUNERAL DIRECTOR Ellsworth Armacost		25a. REC'D BY REGISTRAR FEB 17 1967	
ADDRESS 4600 Liberty Hts. Ave. Baltimore 21207		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

VR A15 (4)
20 M 1/66

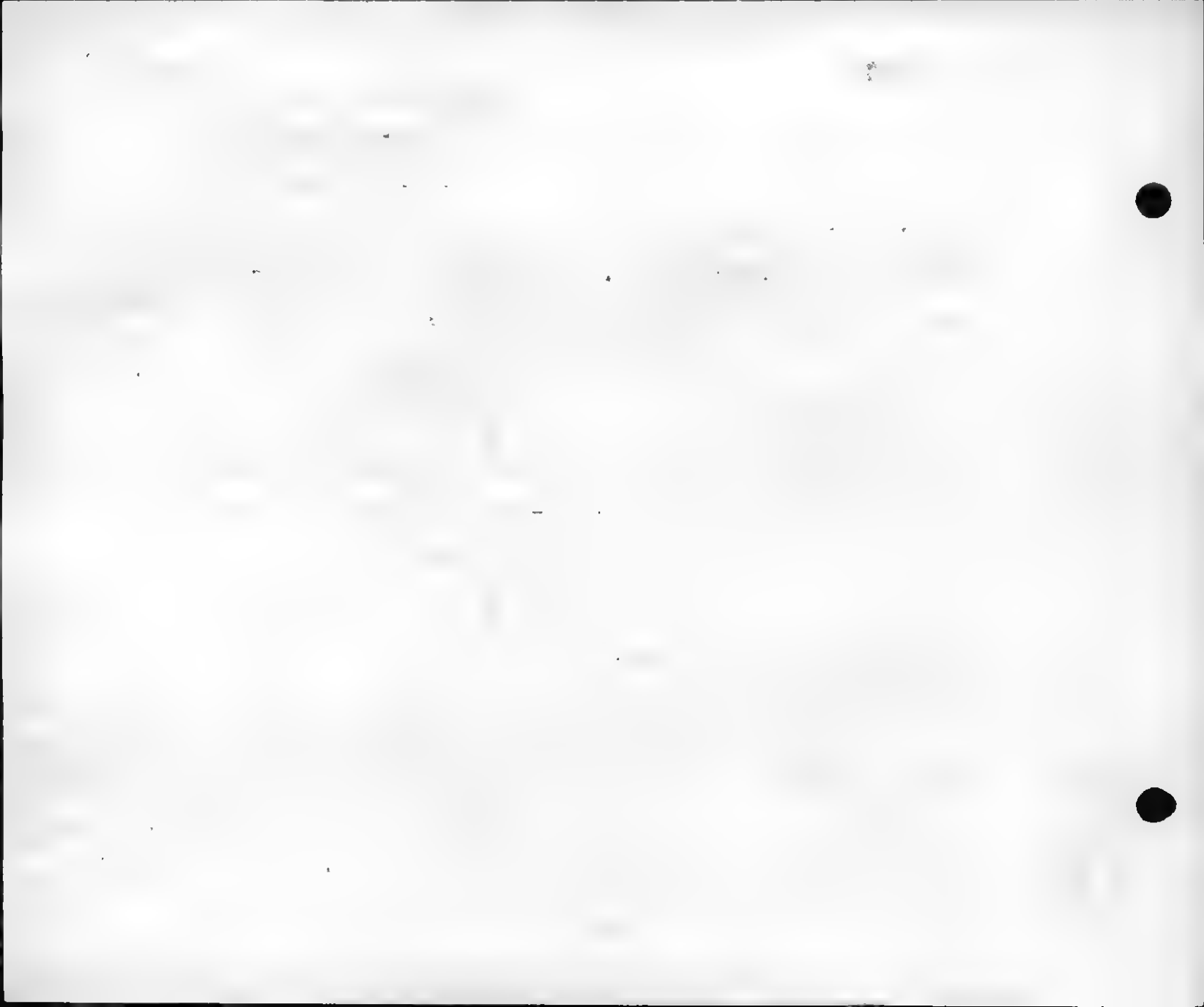
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01861

CERTIFICATE OF DEATH

01857

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY in 1b Baltimore 21206	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		d. STREET ADDRESS 4311 Woodlea Ave	
3. NAME OF DECEASED (Type or print) First Theodore Middle W. Last LE BRAND		4. DATE OF DEATH February 6 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1918
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul J. Le Brand		14. MOTHER'S MAIDEN NAME Ida M. Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 219-03-7930	
17. INFORMANT Mrs. Ida Le Brand		Address 4311 Woodlea Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive antero-lateral myocardial infarction. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 1. Old fibrosed diaphragmatic myocardial infarct. 2. Arteriosclerosis with calcification, coronary arteries.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from February 6, 1967 , to February 6 1967 , that (X) (we) last saw the deceased alive on February 6 1967 , and that death occurred at 2:22 M. from causes and on the date stated above			
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.		22b. DATE SIGNED Feb. 6, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/9/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Park Cemetery	23d. LOCATION (City or Town) (County) (State) Parkville, Md.
24. FUNERAL DIRECTOR Ulrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR FEB 8 1967	25b. REGISTRAR'S SIGNATURE [Signature]

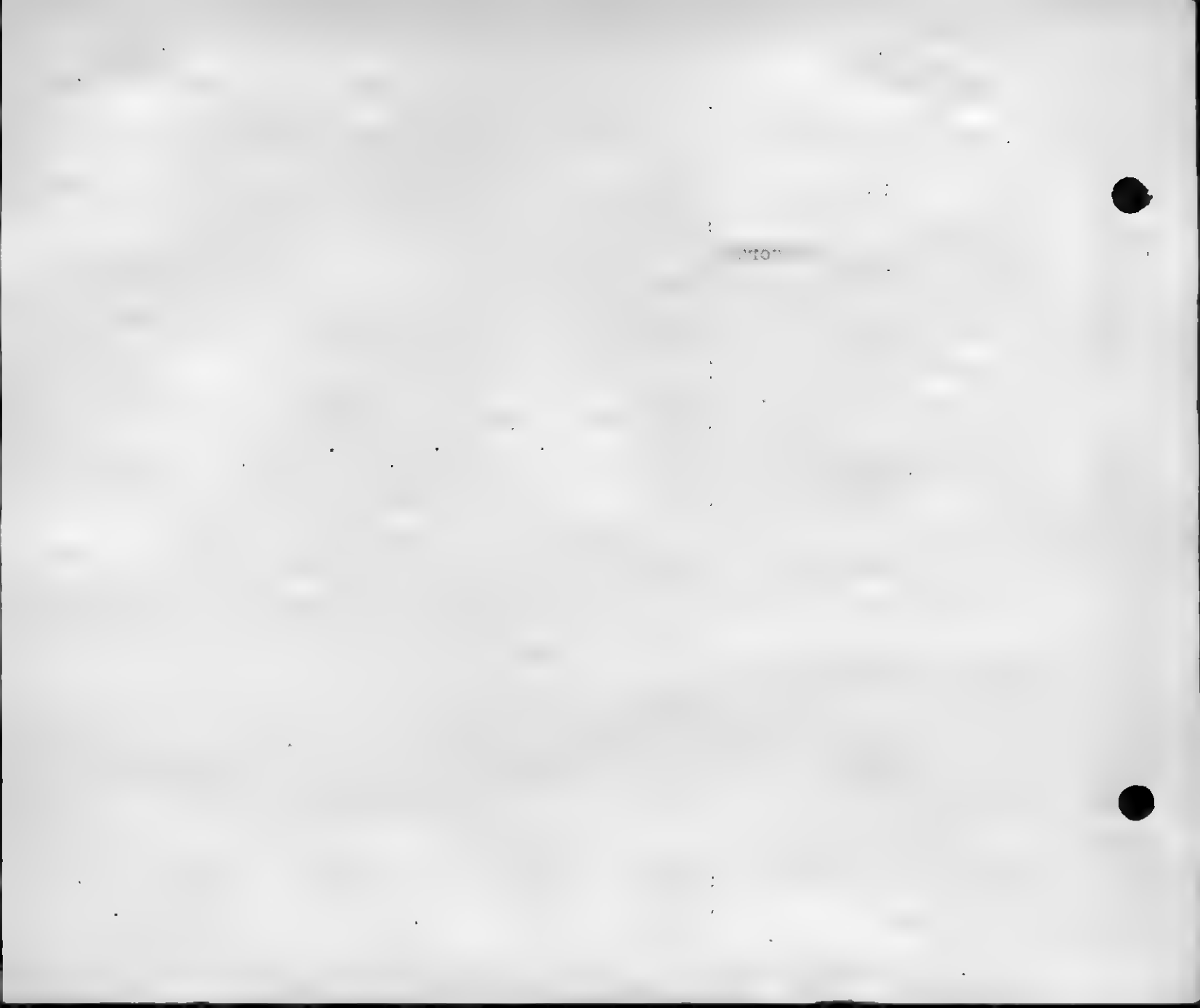


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MD
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01862
CERTIFICATE OF DEATH
01858

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		b. COUNTY Baltimore	
c. LENGTH OF STAY IN it		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2713 Liberty Parkway		d. STREET ADDRESS 2713 Liberty Parkway	
3. NAME OF DECEASED (Type or print) First Middle Last Levera Pratt Lee		4. DATE OF DEATH Month Day Year February 1, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1876
9. AGE (In years last birthday) 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Francis M. Pratt	
14. MOTHER'S MAIDEN NAME Sarah Ann		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Henry W. Lee, Sr. son of deceased	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. (c) } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anterior Alveolar Heart Disease 5 yrs INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1963 to 10/16/66 1967, that (I) (we) last saw the deceased alive on 1-16-1967, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE W. J. Zink		22b. DATE SIGNED 2-1-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 2/1/1967	
23c. NAME OF CEMETERY OR CREMATORY Moravian Cemetery		23d. LOCATION (City, town or county) (State) Forsyth County, N.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Zink & Sons		25a. REC'D BY REGISTRAR DATE FEB 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



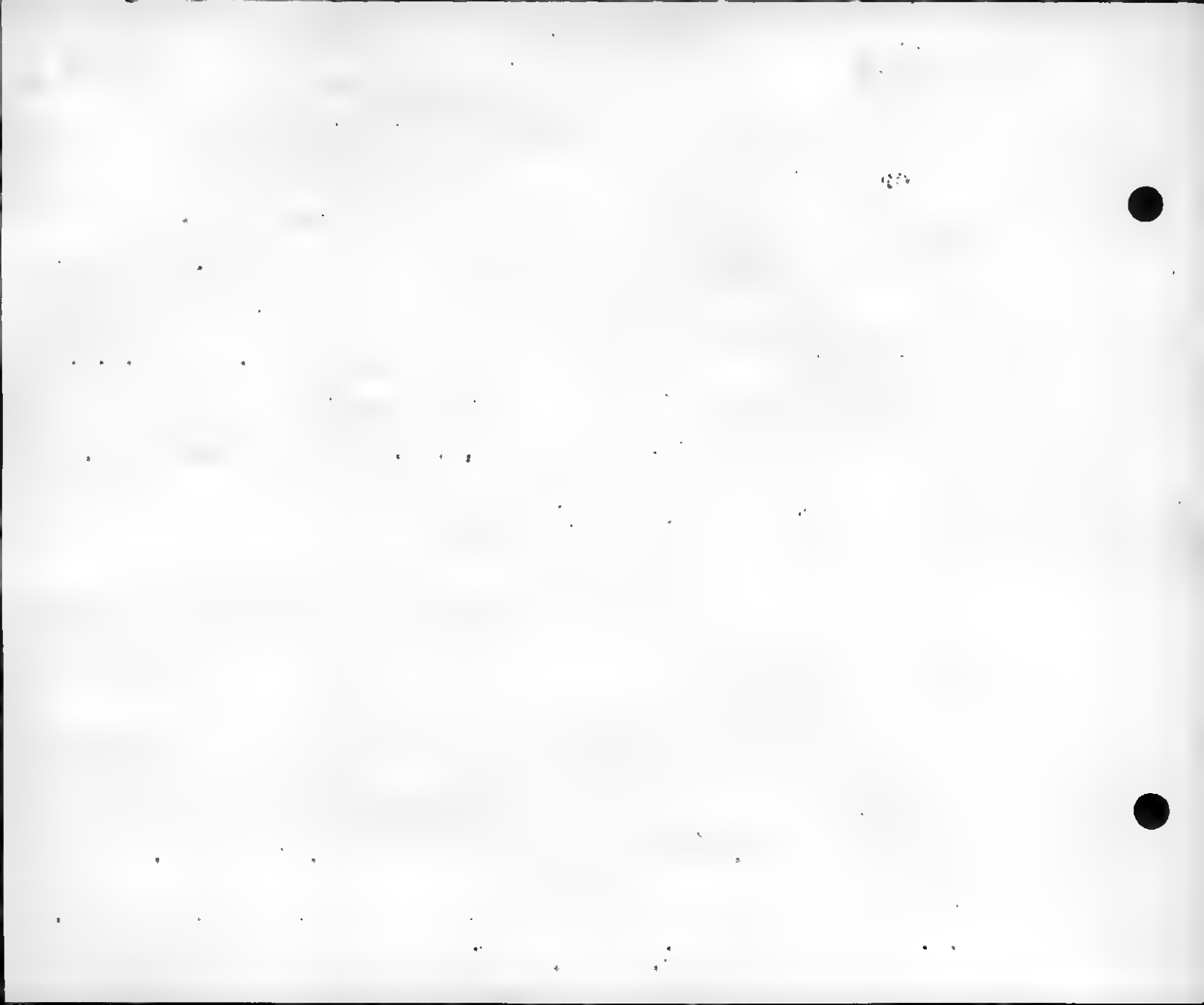
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01863 CERTIFICATE OF DEATH 01859

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 12		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Armco Nursing Home		d. STREET ADDRESS Guilford Towers Apts.	
3. NAME OF DECEASED (Type or print) First Mary Middle Harris Last Lee		4. DATE OF DEATH Month Feb. Day 8 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/1878
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Conklin Harris		14. MOTHER'S MAIDEN NAME Mary Hamilton Kuhn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-46-3741T	
17. INFORMANT Mrs. T. H. Marshall		Address 1715 Circle Road Ruxton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA. DUE TO (b) Cerebral Intermittencies. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 48 hrs. years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1, 1965 to Feb-8, 1966 , that (I) (we) last saw the deceased alive on Feb-8, 1966 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Mark Dugan		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Mark Dugan		22d. ADDRESS 15 E. Biddle St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/10/1967	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR DATE FEB 10 1967	
ADDRESS 4905 York Rd. Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE James Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

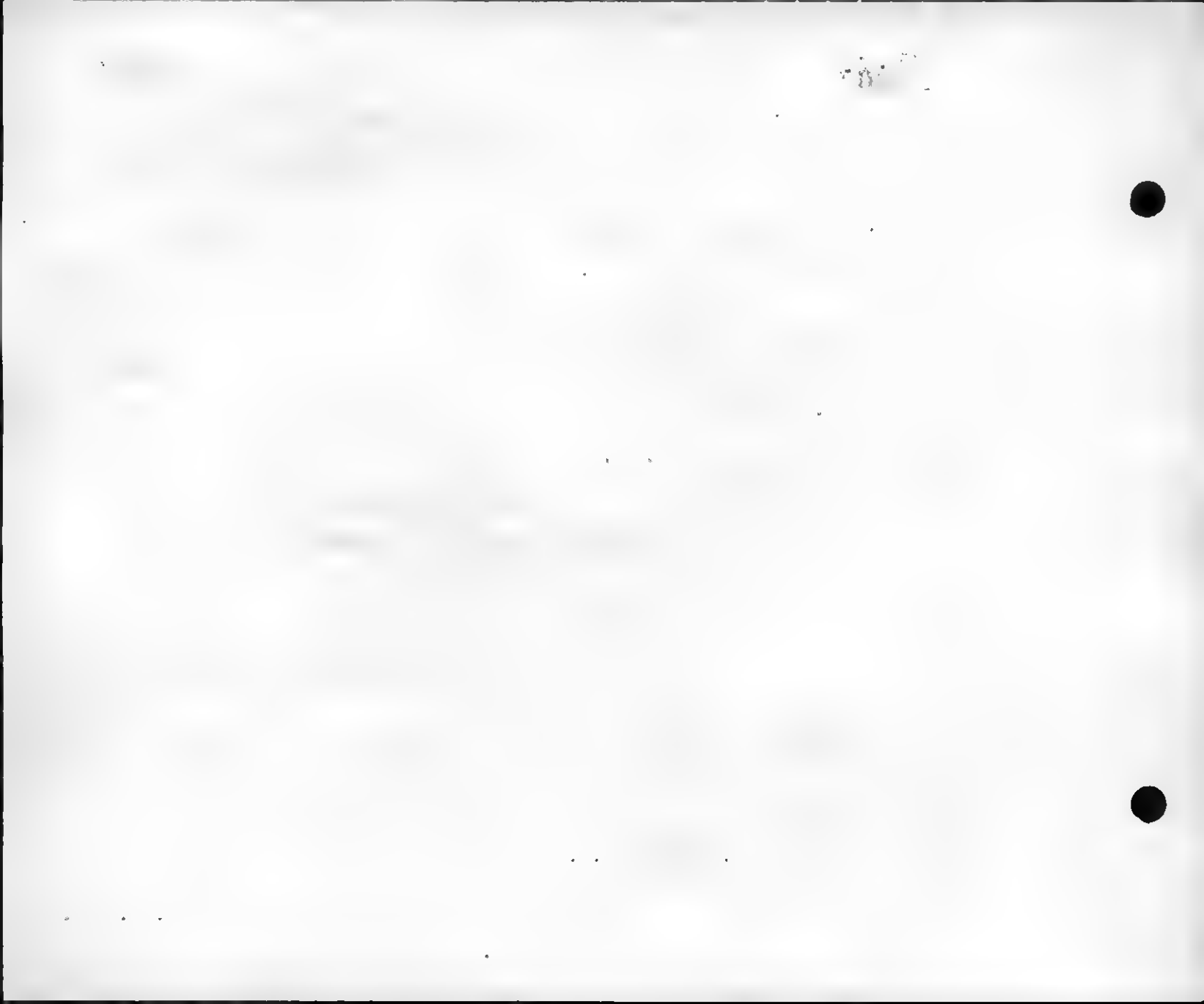
Items 18-21 Film 386 3-14 MARYLAND: STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01864

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01860

1 PLACE OF DEATH a COUNTY BALTIMORE b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN c LENGTH OF STAY IN 1b DOA		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a STATE Maryland b COUNTY BALTIMORE c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN WOODLAWN	
3 NAME OF DECEASED (Type or print) First Edna Middle G. Last LEIST		4 DATE OF DEATH Month February Day 19 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 31, 1877
9 AGE (In years, months, days, hours, minutes) 89		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWN HOME	
10b KIND OF BUSINESS OR INDUSTRY OWN HOME		11 BIRTHPLACE (State or foreign country) MARYLAND	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME LUTHER D. WEBSTER	
14 MOTHER'S MAIDEN NAME MARY BLOOM		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) NO	
16 SOCIAL SECURITY NO. 220.44.5585		17 INFORMANT Miss MARIE E. LEIST Address Same as #2	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Exposure to cold - Associated with fracture of left radius and contusion - Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) lacerations of scalp (c) MENTAL CONFUSION			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental confusion incident to senility			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING? CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Had wandered out of Nursing Home and apparently slipped on ice	
20c TIME OF DEATH Month Day, Year 5:20 AM 2 19 1967		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Driveway - Nursing Home		20f (City or town) (County) (State) Randallstown Balto. Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		22. DATE SIGNED February 20, 1967	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 2/22/67	
23c NAME OF CEMETERY OR CREMATORY WOODLAWN		23d LOCATION (City or town) (County) (State) WOODLAWN BALTO. MD.	
24 FUNERAL DIRECTOR J.T. STANSBURY 6411 WINDSOR MILL RD.		25a REC'D BY REGISTRAR FEB 21 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



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VR A15 (4)
25M 1/67

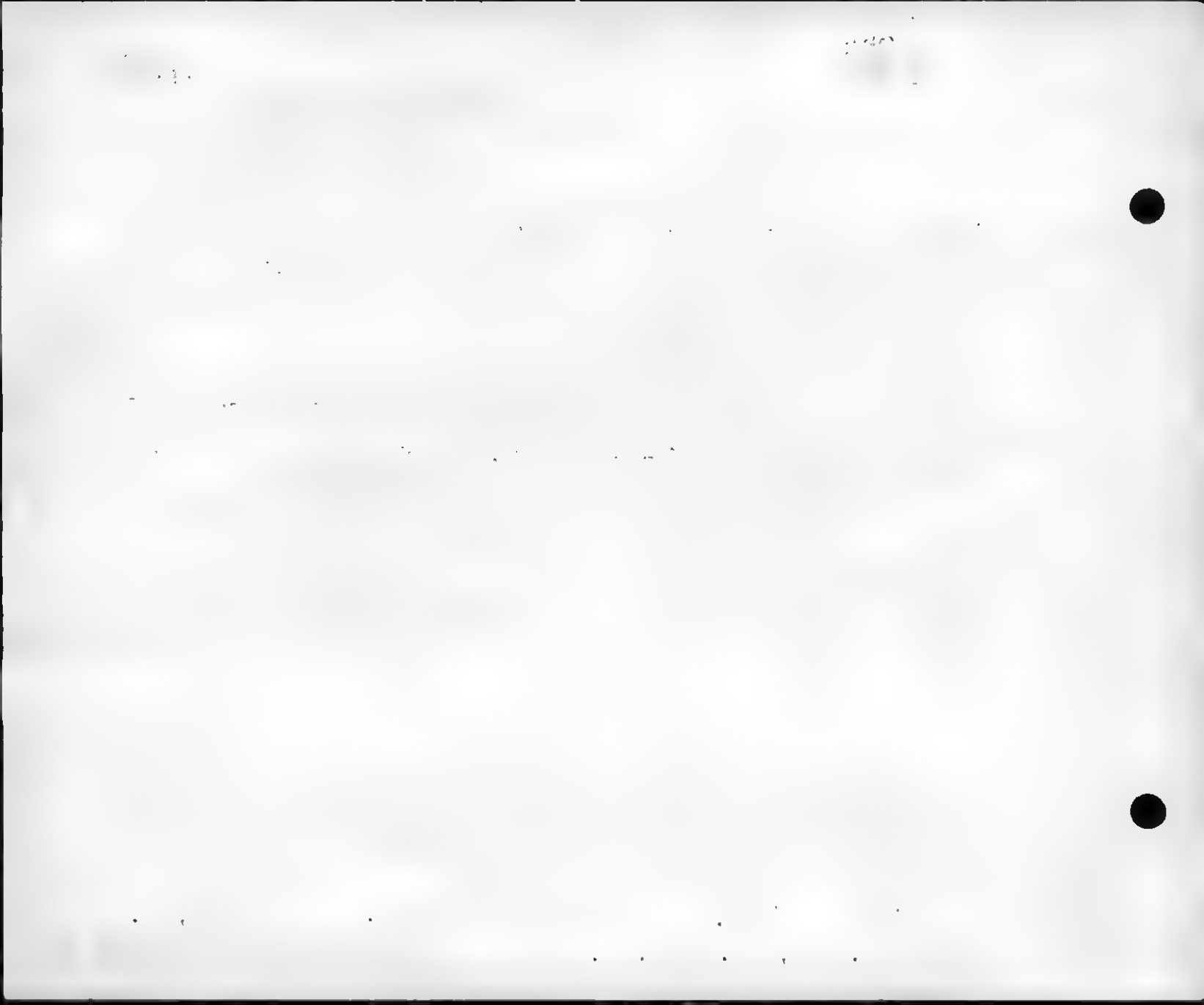
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01865

CERTIFICATE OF DEATH

01861

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admiss on) a STATE MARYLAND b COUNTY BALTIMORE				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c LENGTH OF STAY IN 1b		c CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) BALTIMORE (21204)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER 8227 CARRBRIDGE CIR				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) JOHN FITZHUGH LEONARD				4 DATE OF DEATH FEB. 26 1967				
5. SEX MALE		6 COLOR OR RACE CAUC.		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 11-11-12		
9 AGE (in years most birthday) 54 yrs		F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDING MATERIALS			10b. KIND OF BUSINESS OR INDUSTRY (President)		11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME IRA FITZHUGH LEONARD				14. MOTHER'S MAIDEN NAME XXXXXXXXXX Henrietta Wolle				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO 212-05-8639		17 INFORMANT Mrs. Katherine Leonard		Address (Same)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month Day, Year Hour a.m. p.m. 19			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Feb 16, 1967 , to Feb 26, 1967 , that (I) (we) last saw the deceased alive on Feb 26, 1967 , and that death occurred at 1:30 M, from causes and on the date stated above								
22a SIGNATURE C. C. SHIFF				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED Feb 26, 1967		
22c PHYSICIAN'S NAME (Type) C. C. SHIFF M.D.				22d ADDRESS 6701 N Charles St. GBMC				
23a BURIAL, CREMATION, REMOVA, (Specify) Burial		23b DATE THEREOF 3/1/67.		23c NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Cem.		23d LOCATION (City or Town) (County) (State) Elkridge, Md.		
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a RECD BY REGISTRAR DATE FEB 27 1967		25b REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01866

01862

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 409 S. AUGUSTA AVENUE	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last LEONARD		4 DATE OF DEATH Month FEBRUARY Day 16 Year 67	
5 SEX male	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/2/24 1923
9 AGE (in years last birthday) 43 1/2 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME WILLIAM J. LEONARD		14 MOTHER'S MAIDEN NAME WINFRED ADAMS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW II		16 SOCIAL SECURITY NO 219 10 05 54	
17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 13 MONTHS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that this this hospital attended the deceased from 1/27/67 , 19 67 , to 2/16/67 , 19 67 , that he (we) lost saw the deceased alive on 2/16/67 , 19 67 , and that death occurred at 10:25 AM from causes and on the date stated above.			
22a SIGNATURE <i>George C. McElpatrick, M.D.</i>		22b DATES SIGNED 2/16/67	
22c PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.		22d ADDRESS VAH FORT HOWARD, MARYLAND	
23a BURIAL, CREMATION, REMOVA. (Specify) BURIAL	23b DATE THEREOF 2-20-67	23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24 FUNERAL DIRECTOR <i>John J. Cowan</i>		25a REC'D BY REGISTRAR FEB 20 1967	
ADDRESS COWAN FUNERAL HOME		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01867

CERTIFICATE OF DEATH

01863

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Med. Center</u>		d. STREET ADDRESS <u>110 Skaggsville Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Gladys Elizabeth Reth</u>		4. DATE OF DEATH <u>2/3/67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-05</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR <u>19</u> Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Ritter</u>		14. MOTHER'S MAIDEN NAME <u>Bonnie Bowers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NA</u>	
17. INFORMANT <u>Harry Lett</u>		Address <u>Laurel Md</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastases of pancreatic carcinoma</u> <u>157X</u> DUE TO (b) <u>Pancreatic carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/11/67</u> , 19 <u>67</u> , to <u>2/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/3</u> , 19 <u>67</u> , and that death occurred at <u>9 P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Juan L. Roque</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JUAN L. ROQUE</u>		22d. ADDRESS <u>68 MC Baltimore MD 21204</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify)	23b. DATE THEREOF <u>Feb 5 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore - Carroll - Md</u>
24. FUNERAL DIRECTOR <u>Baltimore</u>	25a. READ BY REGISTRAR <u>DATE FEB 15 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

X

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01868

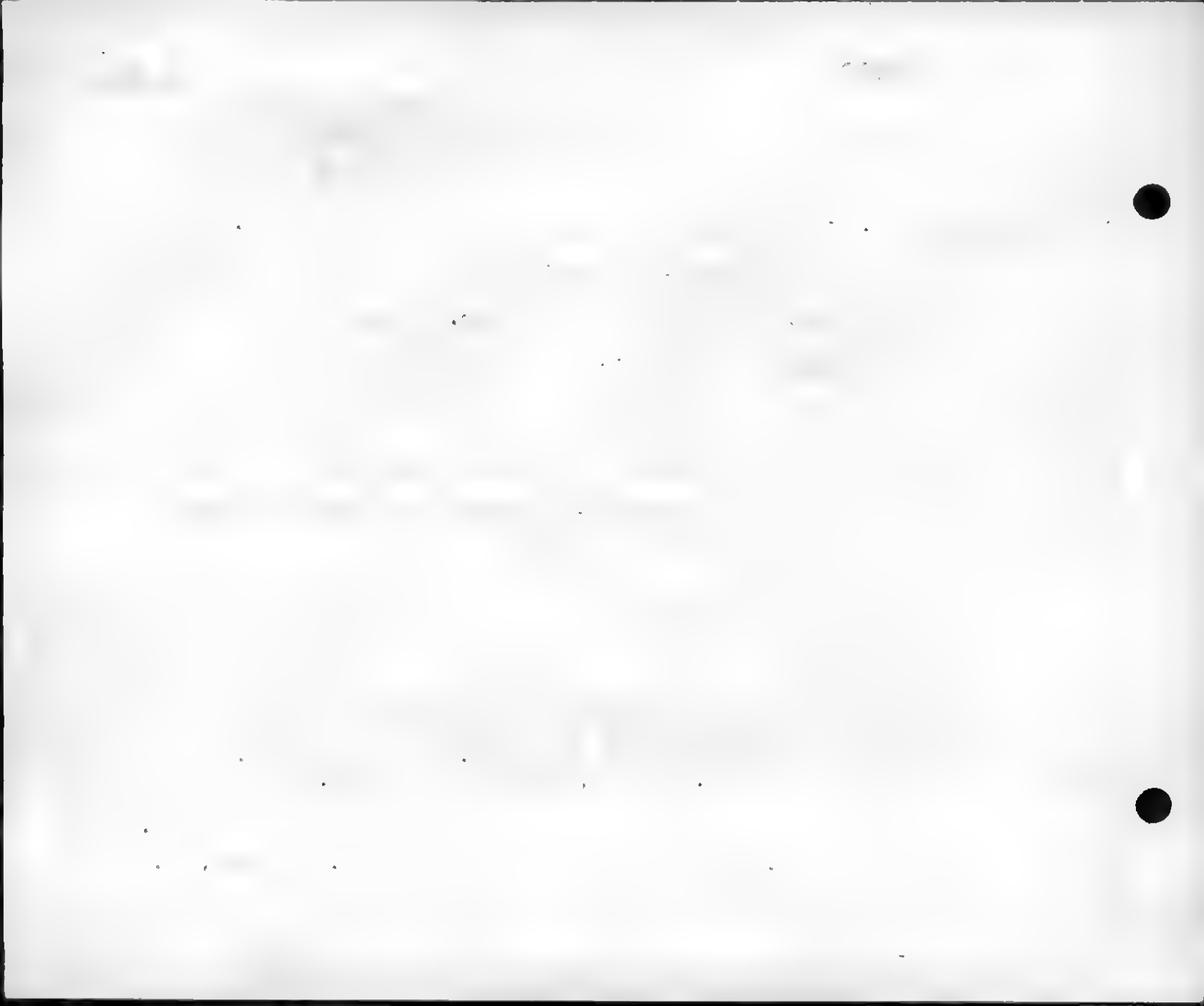
CERTIFICATE OF DEATH

01864

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____				
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore			c LENGTH OF STAY in 1b Life		c CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore 21224			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d STREET ADDRESS 2418 Orleans St.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Middle Last Adam A. Lozanski				4 DATE OF DEATH Month Day Year February 9 1967				
5 SEX male		6 COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 1909 Dec. 24 1909*		
9 AGE (In years last birthday) yrs 57		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min				
10a USUA. OCC. PAT ON (Give kind of work done during most of working life, even if retired) Self-employed			10b KIND OF BUSINESS OR INDUSTRY Mechanic		11. BIRTHPLACE (County & State, or foreign country) Baltimore		12 CIT. ZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WALTER LOZANSKI				14. MOTHER'S MAIDEN NAME BOBBINNA STAFANSKI				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 213 03 4239		17 INFORMANT Mrs. Helen C. Lozanski - 2418 Orleans St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lung with Brain Metastasis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21 I certify that (I) (this hospital) attended the deceased from Jan. 21 , 19 67 , to Feb. 9 , 19 67 , that (I) (we) last saw the deceased alive on Feb. 9 , 19 67 , and that death occurred at 6PM , from causes and on the date stated above.								
22a SIGNATURE Joel V. Tolentine				ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Feb. 9 1967		
22c PHYSICIAN'S NAME (Type) Joel V. Tolentine				22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204				
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 2-13 67		23c NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		23d LOCATION (City or Town) (County) (State) BALTO. MD.		
24. FUNERAL DIRECTOR Garth Miller - 2334 Suffolk St.				25a. REC'D BY REGISTRAR DATE FEB 14 1967		25b REGISTRAR'S SIGNATURE Joe E. Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

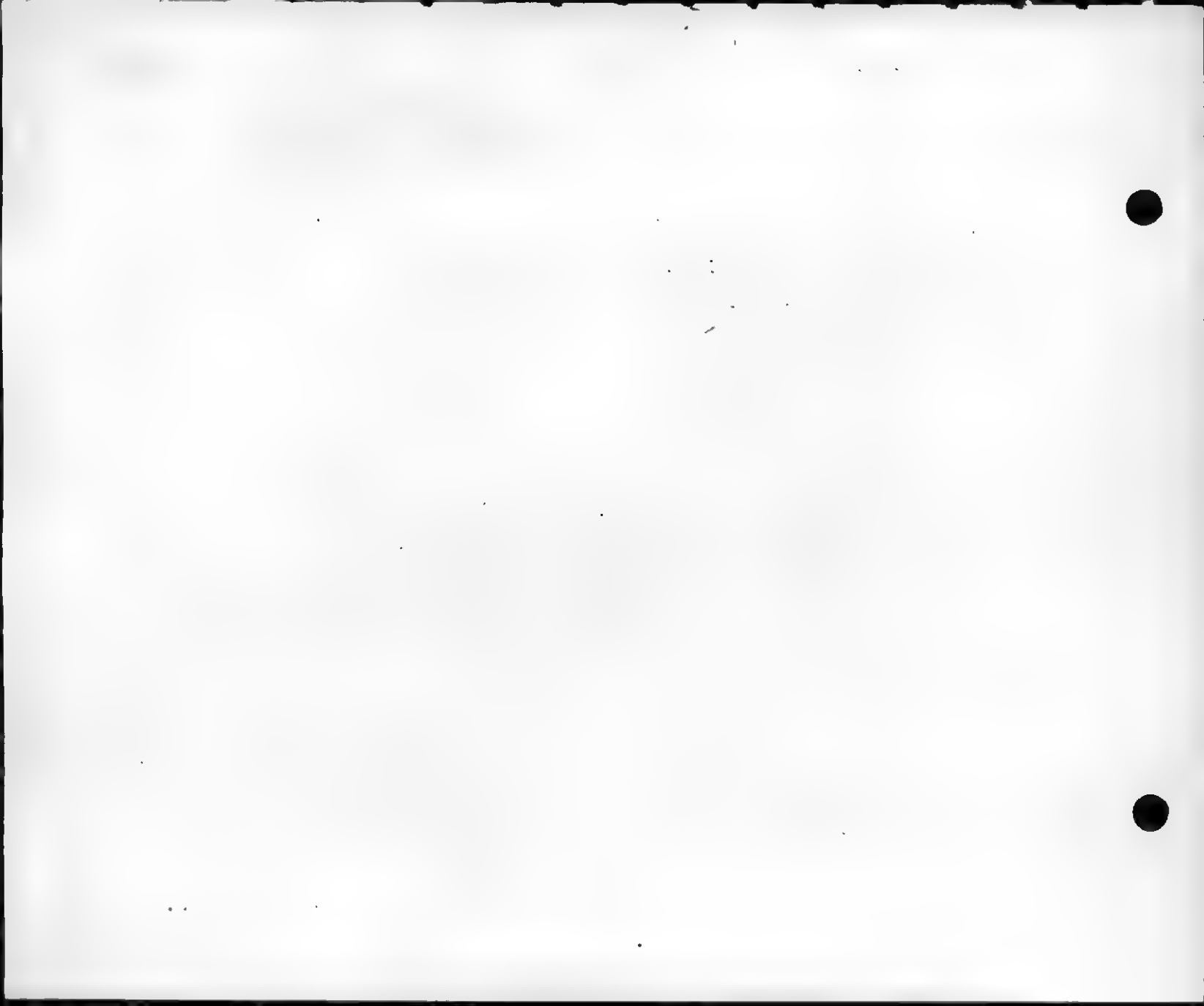
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01869

01865

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MED. CENTER		d. STREET ADDRESS 711 N. MONTFORD AVE.	
3. NAME OF DECEASED (Type or print) GEORGE LEO LOGUE, SR.		4. DATE OF DEATH Month FEBRUARY Day 2 Year 1967	
5. SEX MALE	6. COLOR OR RACE CAU.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-01-09
9. AGE (in years last birthday) 57 yrs.		10. IF UNDER 1 YEAR: Months 57 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN - BALTO CITY		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FELIX LOGUE		14. MOTHER'S MAIDEN NAME CARRIE S. SCHAEFER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-01-5022	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure COX DUE TO (b) Pneumonia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hodgkin's Disease.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Irradiation Ulcer Chest & Back.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-26, 1965 to 2-2, 1967 , that (I) (we) last saw the deceased alive on 2-2, 1967 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 2/2/67	
22c. PHYS. CHANG'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/6/67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Scullin & Son, Inc. 3331 Browns Lane #13		25a. REC'D BY REGISTRAR DATE 6 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01870

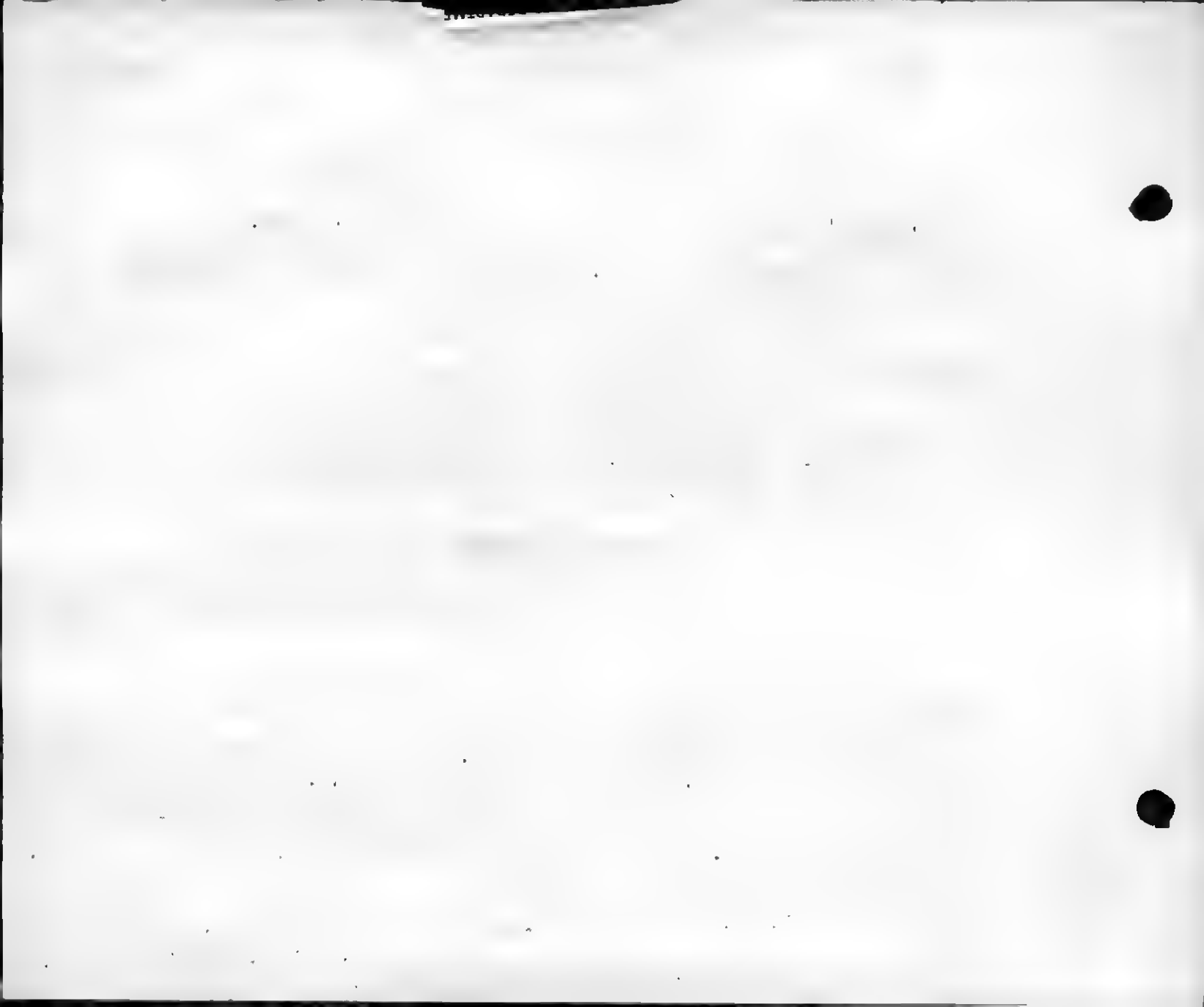
CERTIFICATE OF DEATH

01866

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 c. LENGTH OF STAY in 1b 4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 6211 Marietta Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle F. Last LOSCH		4. DATE OF DEATH Month February Day 18 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/72
9. AGE (in years last birthday) 94 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance	11. BIRTHPLACE (County & State, or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ? Losch	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 215-07-0117		17. INFORMANT Raymond C. Bussey Sr. (Step-Son) Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cerebral thrombosis 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) terminal pneumonia DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 15 , 19 67 , to Feb 18 , 19 67 , that (I) (we) last saw the deceased alive on Feb. 18 , 19 67 , and that death occurred at 9P.M. , from causes and on the date stated above.			
22a. SIGNATURE Fiorello G. Malit		22b. DATE SIGNED 2-18-67	
22c. PHYSICIAN'S NAME (Type) Fiorello G. Malit		22d. ADDRESS 7620 York Road, Baltimore 21204, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Salladasburg Cemetery	23d. LOCATION (City or Town) (County) (State) Salladasburg Penna.
24. FUNERAL DIRECTOR Eugenia K. Seitz Seitz Funeral Home		25. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 21 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

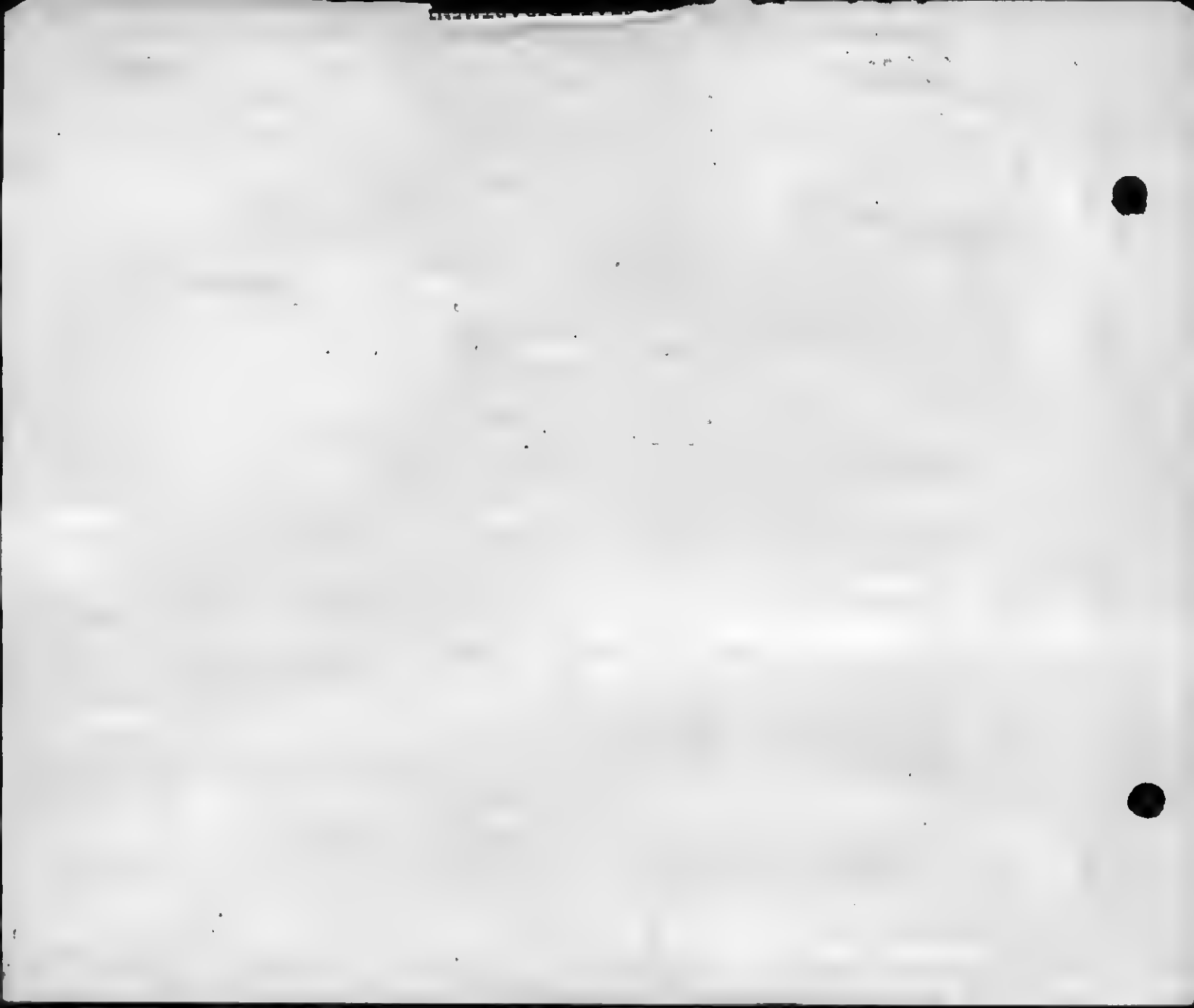
01871

01867

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 617 Aldershot Road 21229		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Raymond H. Lyeth		4. DATE OF DEATH Month February		Day 13,		Year 1967		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 28, 1885		9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 81		11. IF UNDER 24 HRS. Days 81		Hours 81		Min. 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contract Carrier		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (County & State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? Baltimore, Md.		13. FATHER'S NAME Samuel Lyeth		14. MOTHER'S MAIDEN NAME Catherine		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 217-01-1218		17. INFORMANT Mrs. Mollie Lyeth		Address same address as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks. 6 wks.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from 12-24, 1963 to 2-13, 1967 , that (I) (we) last saw the deceased alive on 2-10, 1967 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.		22a. SIGNATURE Wilmer K. Gallager, Jr.		22b. DATE SIGNED 2-13-67		22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallager, Jr.		22d. ADDRESS 6209 Frederick Ave. Baltimore 28 Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/>		22g. STAFF PHYS. <input type="checkbox"/>		22h. REGISTRAR'S SIGNATURE Charles Judge									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/15/1967		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) Woodlawn, Md.		23e. REC'D BY REGISTRAR FEB 14 1967		23f. REGISTRAR'S SIGNATURE Charles Judge		23g. ADDRESS Baltimore, Md.		23h. DATE FEB 14 1967		23i. REGISTRAR'S SIGNATURE Charles Judge									

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

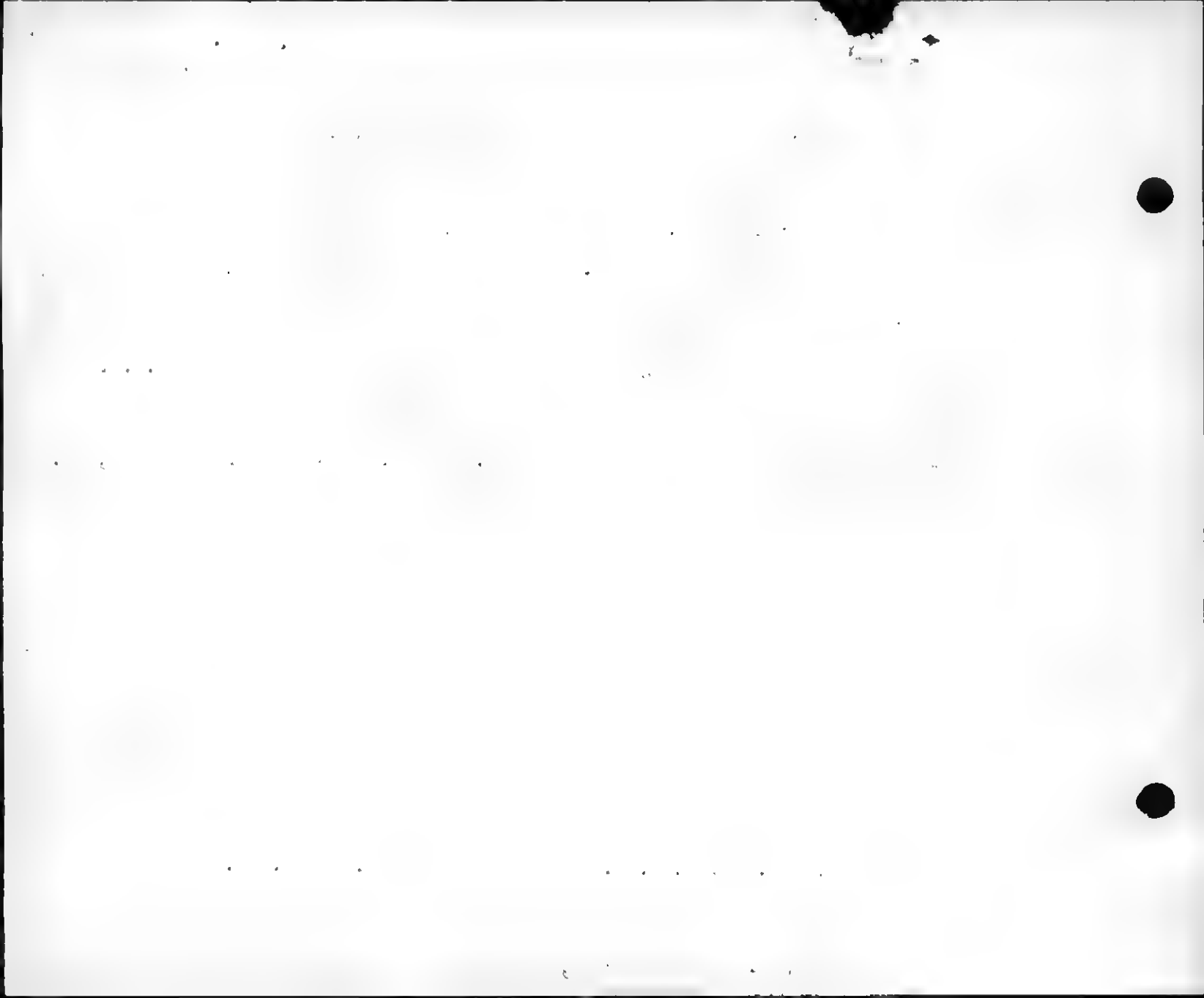
FOR STATE HEALTH DEPT.

01872

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01868

1 PLACE OF DEATH a. COUNTY BAITIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1815 BARCLAY STREET	
3 NAME OF DECEASED (Type or print) First ARTHUR Middle D. Last MADDEN		4 DATE OF DEATH Month FEBRUARY Day 24 Year 1967	
5. SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/24/21
9 AGE (In years last birthday) yrs 45		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b KIND OF BUSINESS OR INDUSTRY ODD JOBS	
11 BIRTHPLACE (State or foreign country) BAITIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME JOSEPH MADDEN		14 MOTHER'S MAIDEN NAME FANNIE HUNTER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16 SOCIAL SECURITY NO 212 14 35 54	
17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURE CERVICAL SPINE C5 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 32 DAYS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) FALL DOWN STAIRS	
20c TIME OF INJURY Month, Day, Year Hour a.m. 1/23/ 19 67 p.m.		20d INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore, Maryland		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE MELVIN B. DAVIS, M. D.		22. DATE SIGNED 2/24/67	
EXAMINER'S NAME (Type) MELVIN B. DAVIS, M. D.		6800 Mornington Rd., Balto., Md. 21222	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 3-1-67	23c NAME OF CEMETERY OR CREMATORY BAITIMORE NATIONAL	23d LOCATION (City or Town) (County) (State) BAITIMORE, MARYLAND
24 FUNERAL DIRECTOR RAYNER SANDERS		25a REC'D BY REGISTRAR DATE FEB 8 1967	
FUNERAL HOME, 217 E. Preston Street, Baltimore		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

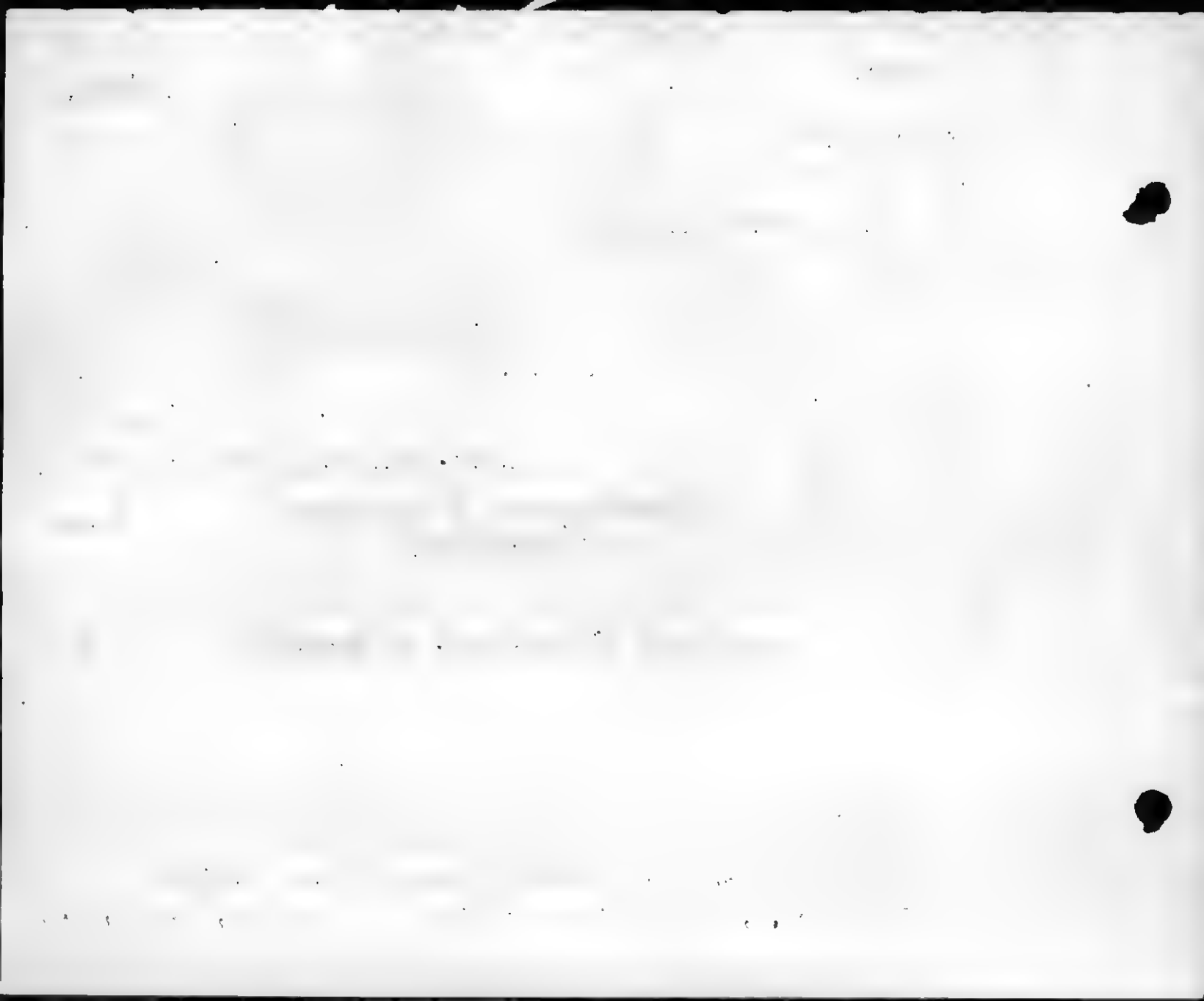
01873

CERTIFICATE OF DEATH

01869

Item #7 Film #G308 5/2/67

1. PLACE OF DEATH a. COUNTY Baltimore County				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles Co.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson				c. LENGTH OF STAY IN 1b 7 mo			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital				d. STREET ADDRESS Nanjemoy (Rural)			
3. NAME OF DECEASED (Type or print) First Earl Middle — Last Maddox				4. DATE OF DEATH Month 2 Day 6 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3.22.02	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b. KIND OF BUSINESS OR INDUSTRY U.S.N.P.P.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Maddox				14. MOTHER'S MAIDEN NAME Maria Posey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-32-973		17. INFORMANT Records, Mt. Wilson State Hospital			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) E metastases DUE TO (c) Minimal Pulmonary Tuberculosis						INTERVAL BETWEEN ONSET AND DEATH 9 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6.14.1966 , to 2.6.1967 , that (I) (we) last saw the deceased alive on 2.6.1967 , and that death occurred at 2:25 M, from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer				22b. DATE SIGNED 2.6.67			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Nanjemoy Baptist		23d. LOCATION (City, town or county) (State) Nanjemoy, Charles, Md.	
24. FUNERAL DIRECTOR Charles Judge				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01874

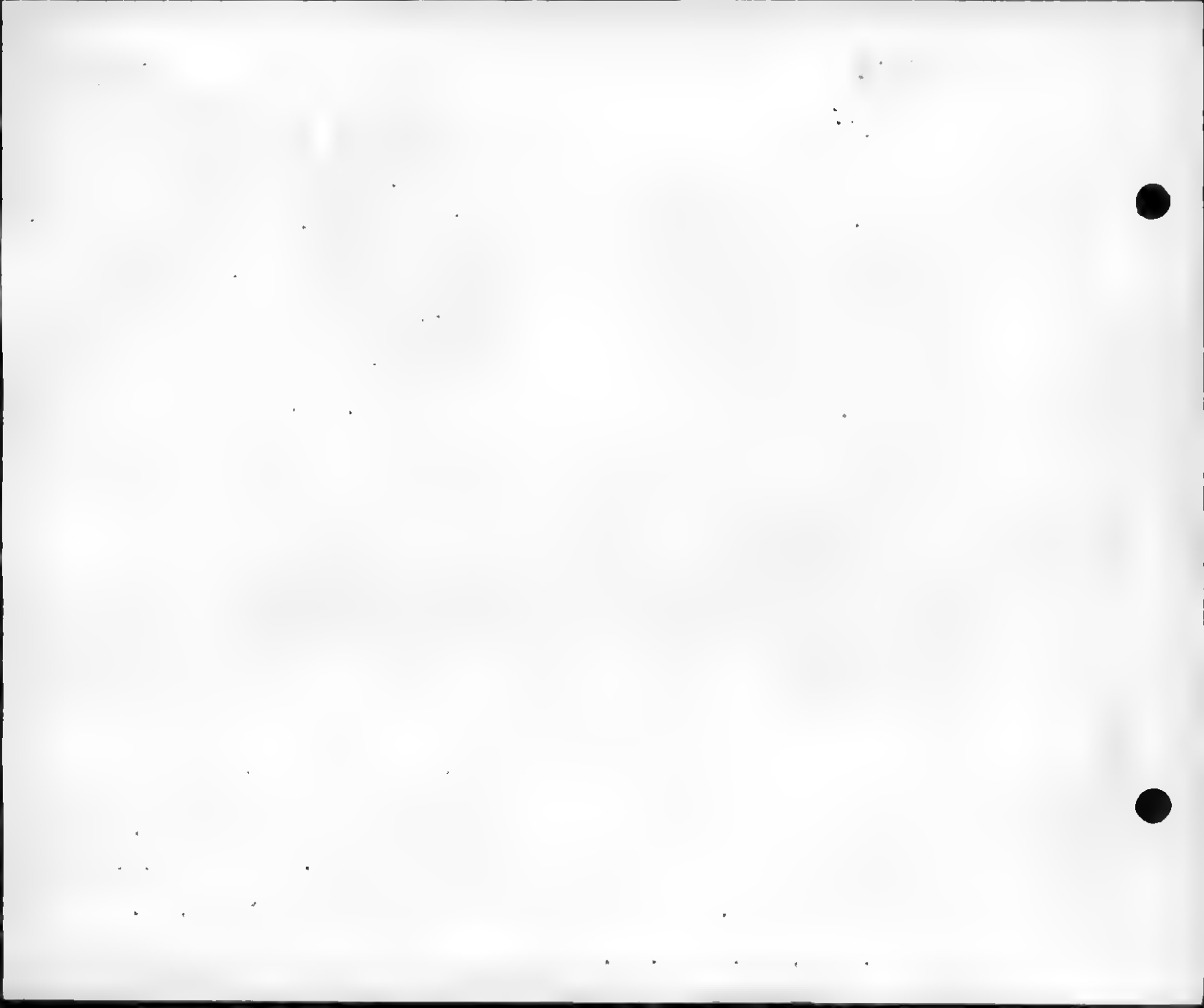
CERTIFICATE OF DEATH

01870

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Baltimore 21204</u>	
d. NAME OF HOSP TAL OR INSTITUT ON (If nat in hospital, give street address) <u>St. Joseph Hospital</u>		d. STREET ADDRESS <u>1674 Mussula Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>Malthan</u> Last <u></u>		4. DATE OF DEATH Month <u>February</u> Day <u>4</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/3/67</u>
9. AGE (In years last birthday) yrs <u>43</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles D. Malthan</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor R. Clary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Parents</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>Immaturity</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 3</u> , 19 <u>67</u> , to <u>Feb. 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 4</u> , 19 <u>67</u> , and that death occurred at <u>9:25 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Jose S. Aguto</u>		22b. DATE SIGNED <u>Feb. 4 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jose S. Aguto</u>		22d. ADDRESS <u>7620 York Rd. Baltimore, Md. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/6/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u></u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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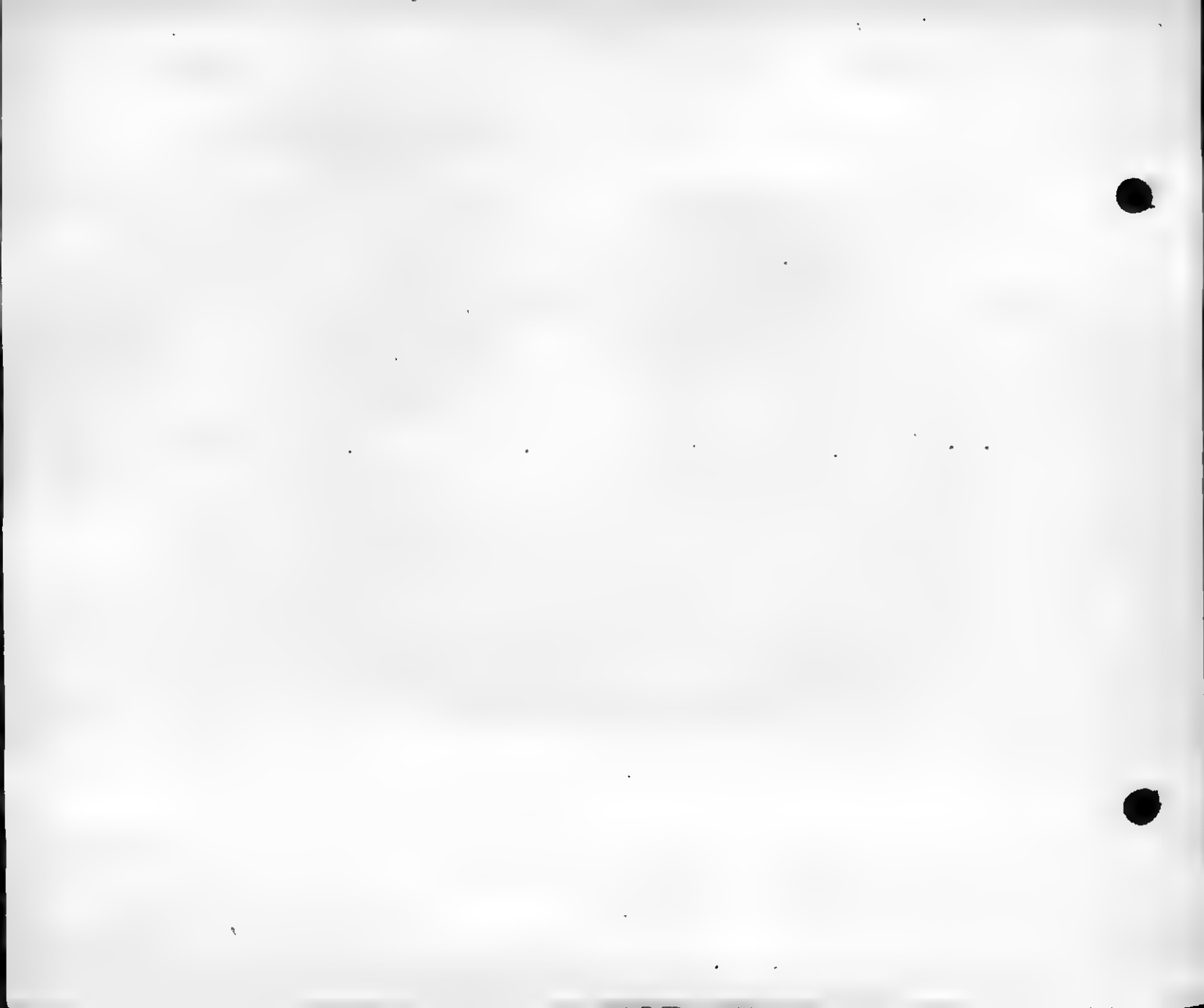
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01879

01875

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3204 Woodvalley Drive #8</u>				d. STREET ADDRESS <u>3204 Woodvalley Drive #8</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jack L. Mazer</u>				4. DATE OF DEATH Month Day Year <u>February 9, 19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1916</u>		9. AGE (In years last birthday) <u>50</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham Mazer</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Horwitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>W. W. 11 Army</u>		16. SOCIAL SECURITY NO <u>216-09-1695</u>		17. INFORMANT Address <u>Mrs. Frances Mazer, 3204 Woodvalley Drive #8</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>ASCVD</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-1966</u> to <u>2-9-1967</u> that (I) (we) last saw the deceased alive on <u>2-4-1967</u> and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>James J. Collins</u>				22b. ADDRESS <u>2217 South Rd</u>		22c. PHYSICIAN'S NAME (Type) <u>James J. Collins MD</u>	
22d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. DATE SIGNED					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth Tfiloh</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u>				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

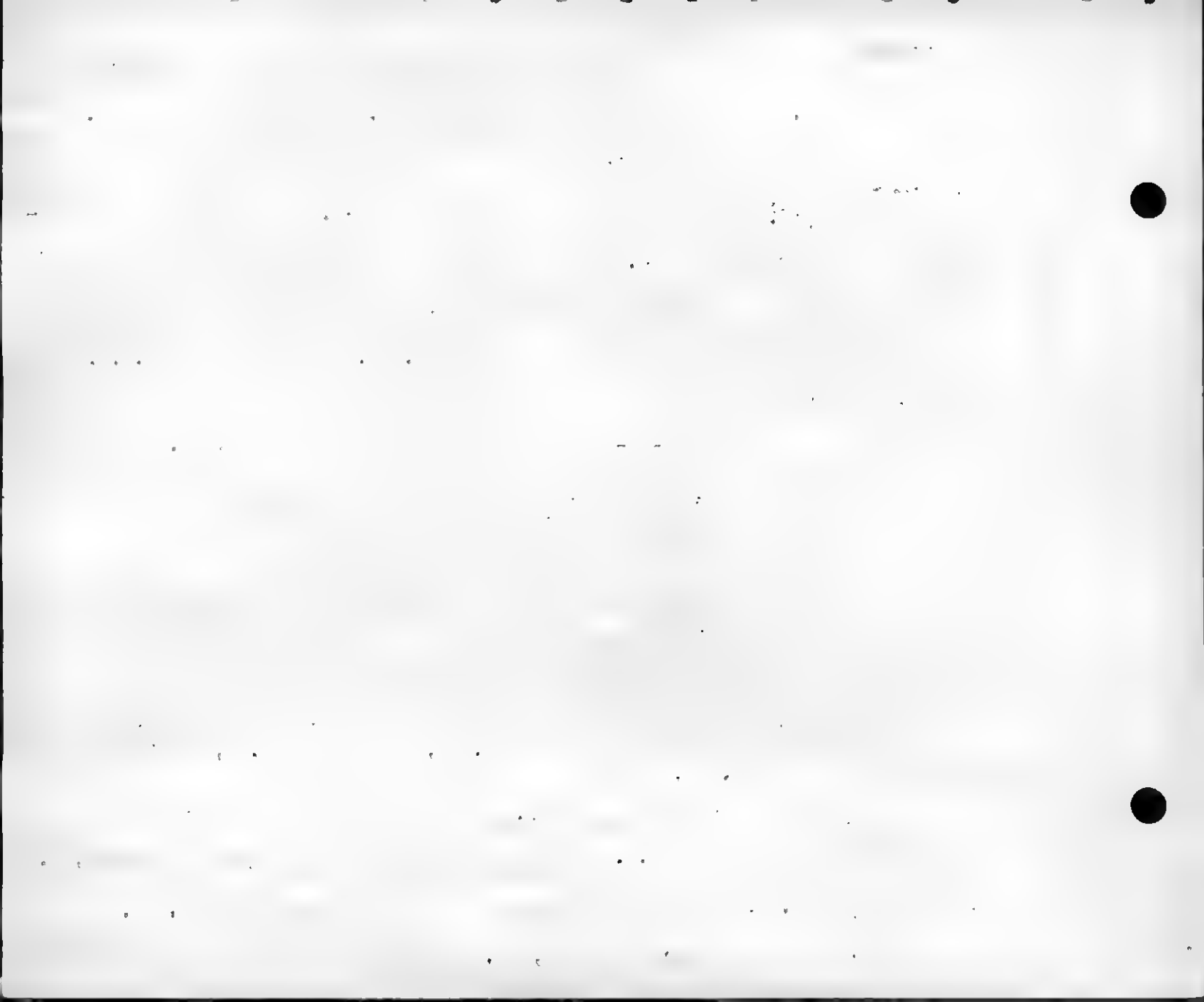


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01875		01871	
1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>Black Rock Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Black Rock Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>J.</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>5,</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31, 1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Armacost</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-48-1516</u>	
17. INFORMANT <u>Mrs. Helen Bentz</u>		Address <u>Upperco, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>Arteriosclerotic Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 26,</u> 19 <u>62</u> , to <u>Feb. 5,</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 3,</u> 19 <u>67</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush M.D.</u>		22b. DATE SIGNED <u>2/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		22d. ADDRESS <u>117 S. Main Street Hampstead, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grace Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Upperco Balto. Co.</u>
24. FUNERAL DIRECTOR <u>Tipton- Eline Funeral Home Hampstead, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 8 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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20 M 1/66

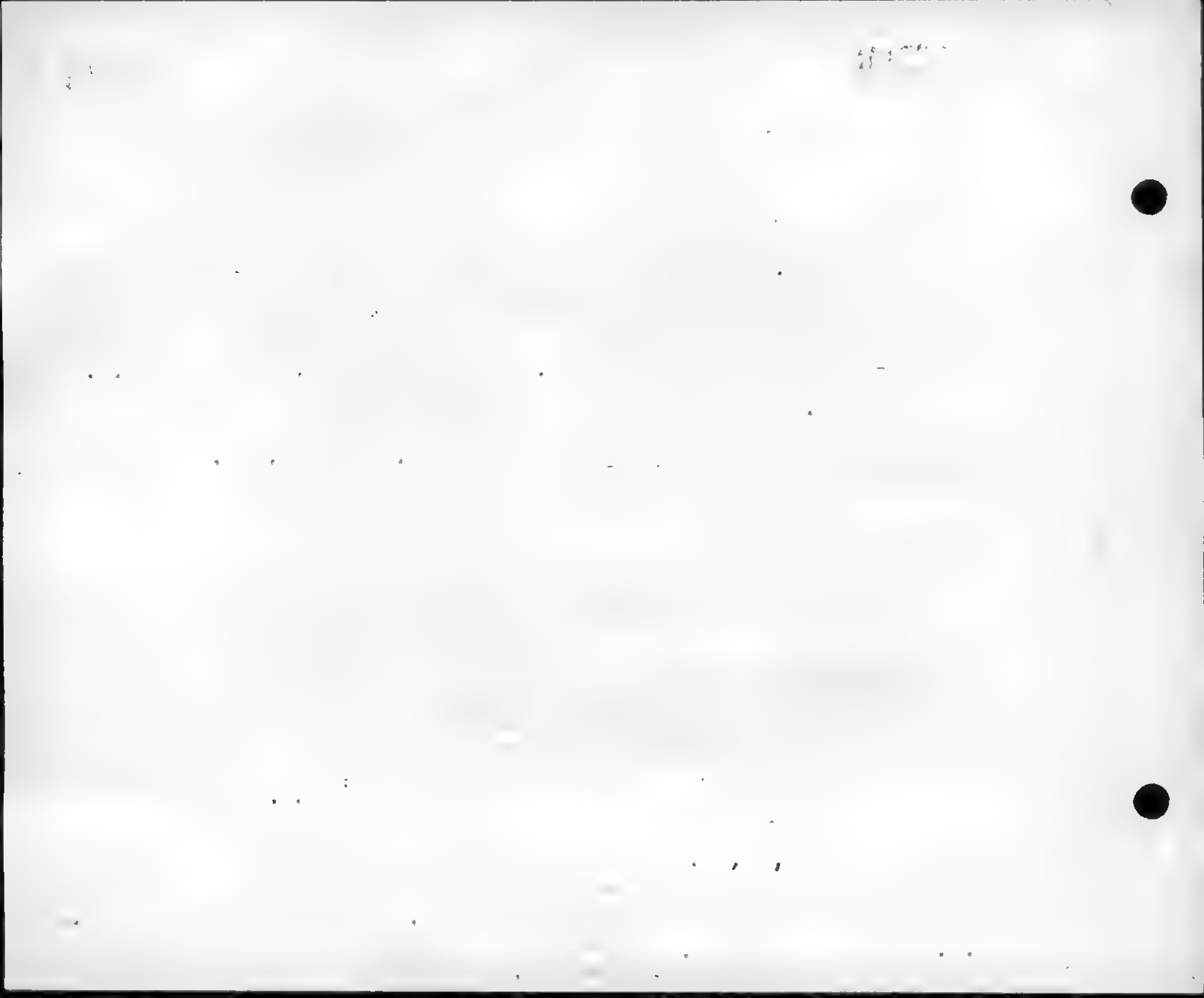
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01876

CERTIFICATE OF DEATH

01872

1 PLACE OF DEATH a. COUNTY Baltimore, MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY —	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY IN 1b 30-4	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home		e STREET ADDRESS 321 Taplow Road	
3. NAME OF DECEASED (Type or print) First Middle Last Miss. Pauline Regina Mathaney		4 DATE OF DEATH Month Day Year February 14th. 19 67	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/1881
9 AGE (In years last birthday) 85 yrs.		F UNDER 1 YEAR Months Days Hours Min 12 CITIZEN OF WHAT COUNTRY? U.S.A.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Buyer		10b. KIND OF BUSINESS OR INDUSTRY Stewart & Co.	
11 BIRTHPLACE (County & State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William F. Mathaney		14. MOTHER'S MAIDEN NAME Amanda Melvin	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 215-03-2504	
17 INFORMANT Howland S. Roberts, Sr.		Address (Same)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TUMOR DUE TO (b) CEREBRI DUE TO (c) SWELLING		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. NONE		20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Jan. 15, 1966 to Feb. 14, 1967 , that (I) (we) last saw the deceased alive on Feb. 13, 1967 , and that death occurred at 11:10 AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. A. S. Chalfant		22b. DATE SIGNED Feb 14 67	
22c PHYSICIAN'S NAME (Type) Dr. A. S. Chalfant		22d ADDRESS 6210 York Road	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR DATE FEB 15 1967	
ADDRESS 4905 York Road Baltimore 12, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01877

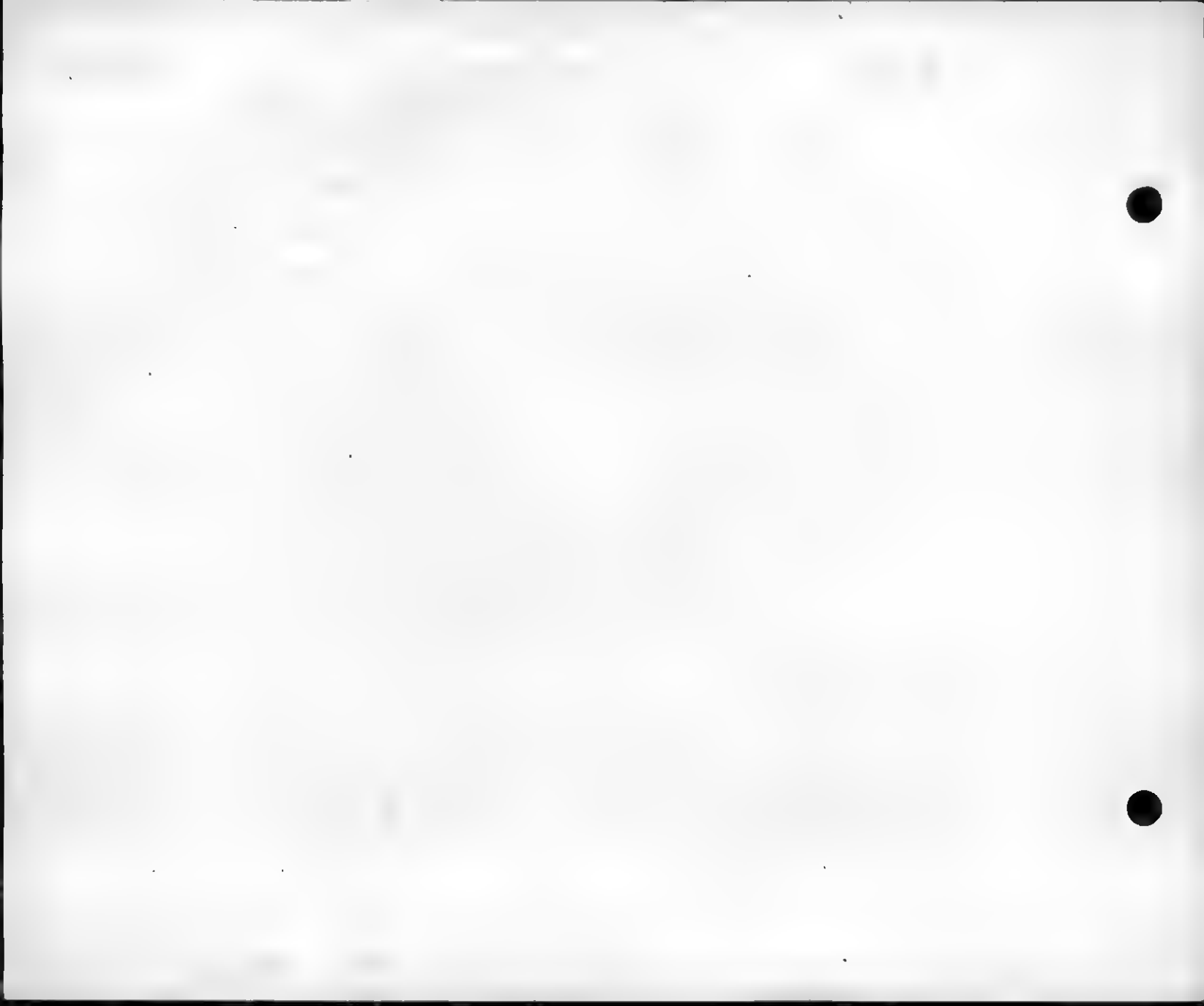
CERTIFICATE OF DEATH

01873

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus d. STREET ADDRESS 1232 Maiden Choice Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Pauline K. Matthiesen First Middle Last Female White WIDOWED NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 5. SEX 6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 7-4-1890 9. AGE (In years last birthday) 76 yrs.			4. DATE OF DEATH February 26, 1967 Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Ferdinand Krahn 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Frederick W. Matthiesen, 1232 Maiden Address Choice Lane			14. MOTHER'S MAIDEN NAME Katherina Snyder 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hyper tension U.S.C.V.E. 5271 DUE TO (b) Grade IV Congestive Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Emp Hysemia (Severe) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (COND TION GIVEN IN PART I(a)) Chronic Bronchitis (Bronchitis)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan, 1967, to 2/26, 1967, that (I) (we) last saw the deceased alive on 2/25, 1967, and that death occurred at 9:30 A.M. from causes and on the date stated above							
22a. SIGNATURE Dr. John C. Healy 22c. PHYSICIAN'S NAME (Type) Dr. John C. Healy 22d. ADDRESS 1311 Francis Ave. Balto, Md. 21227			22b. DATE SIGNED 2/27/67 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, BY WHOM (Specify) BURIAL		23b. DATE THEREOF 3-1-1967		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery			
24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 Wilkens Ave. 21229		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE MAR 1 1967 <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on the event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

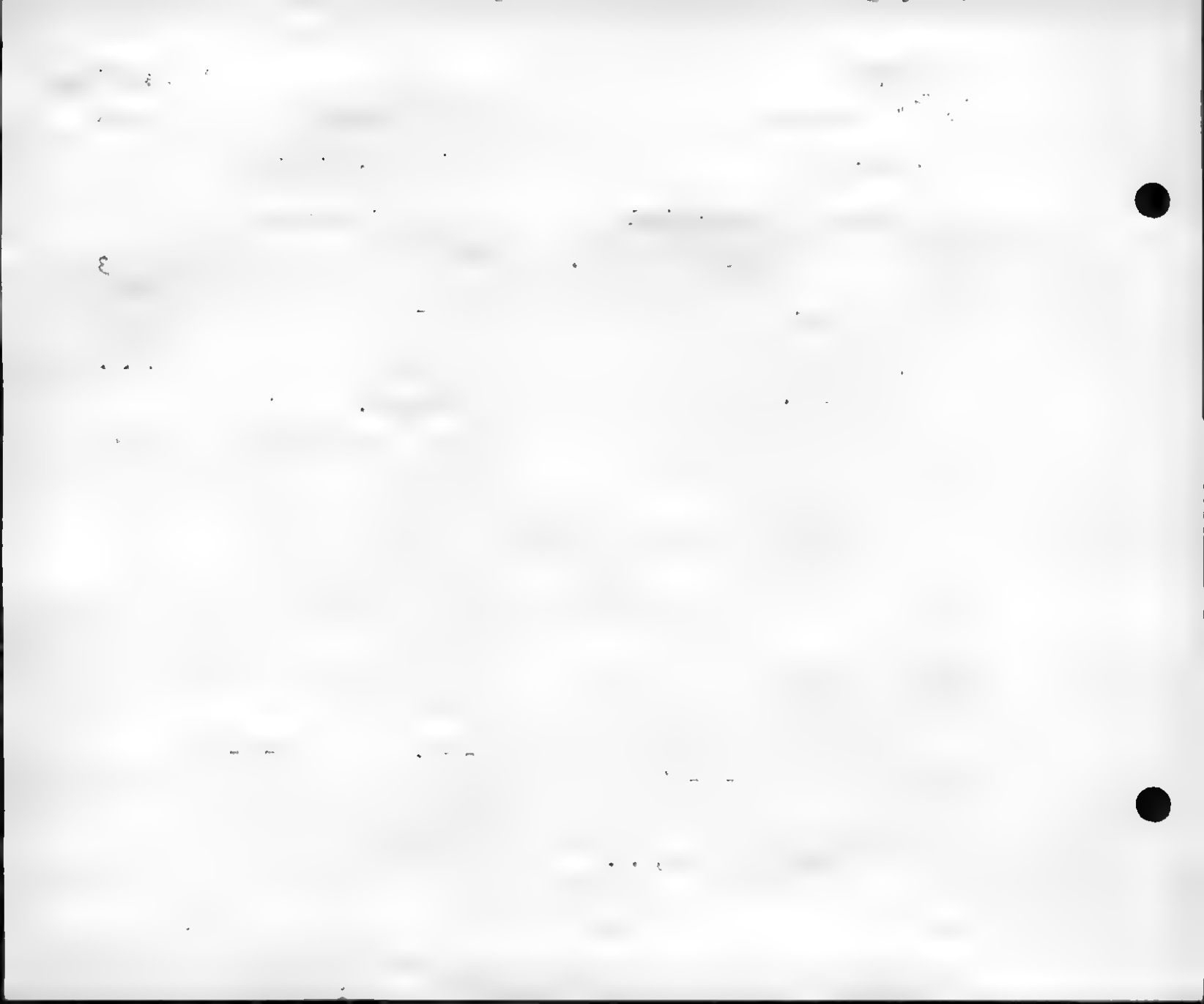
01878

CERTIFICATE OF DEATH

01874

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Balto	
b CITY OR TOWN (If outside corporate limits, write nearest town) Catonville		c LENGTH OF STAY IN 1b Timonium, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 204 Ridgley Road	
3 NAME OF DECEASED (Type or print) Grace V. Mayes		4 DATE OF DEATH Month February Day 13 Year 1967	
5. SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-23-27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years lost birthday) yrs 39
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Galloway		14. MOTHER'S MAIDEN NAME Grace B. Budnitz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-24-0010	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) epilepsy - status epilepticus DUE TO (b) multiple sclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-7-66 , 19____, to 2-13-67 , 19____, that (I) (we) lost the deceased alive on 2-13-67 , 19____, and that death occurred at 2:20 P.M. from causes and on the date stated above			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 2/13/67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/15/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park Cem	23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto.		25a. REC'D BY REGISTRAR FEB 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



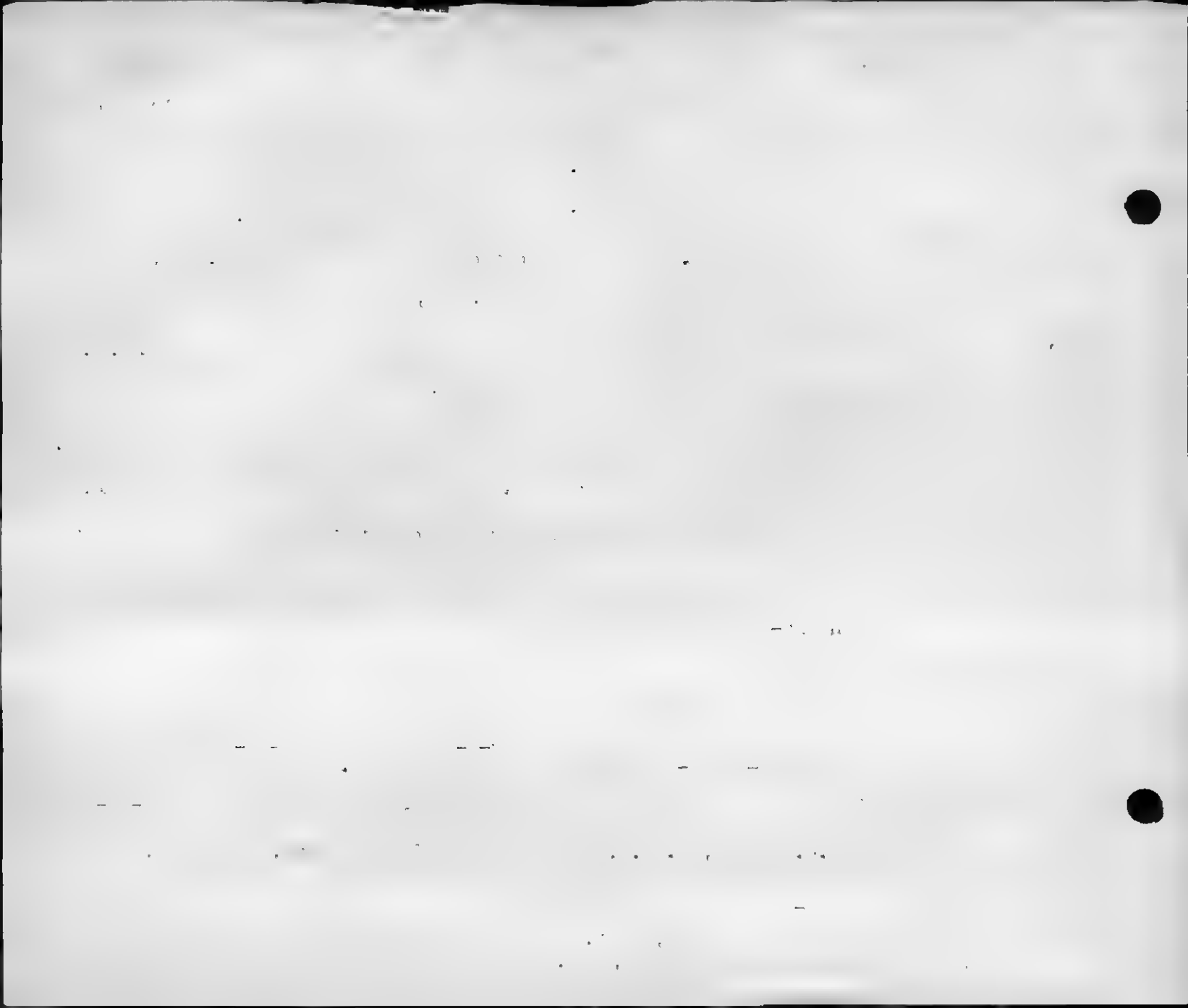
01880

CERTIFICATE OF DEATH

01876

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY in 1b <u>3 Mo.</u>		d. STREET ADDRESS <u>Hopkins Apts.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Presbyterian Home of Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clare B.</u> Middle <u>McCance</u> Last <u>McCance</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 30, 1881</u>
9. AGE (in years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Will Brothers</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Waddington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Records of Presbyterian Home of Md.</u>	
17. INFORMANT <u>Records of Presbyterian Home of Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>4/2/71</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u> </u> DUE TO (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia- etiology undetermined</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (My presence) attended the deceased from <u>6-4-66</u> , 19 <u> </u> , to <u>2-18-67</u> , 19 <u> </u> , that (I) (you) last saw the deceased alive on <u>2-15-1967</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>2-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S.J. Venable, Jr. M.D.</u>		22d. ADDRESS <u>7215 York Road, Baltimore, Md 21212</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-21-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City, town or county) (State) <u>Woodlawn, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mitchell-Wiedefeld Home, Inc.</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. ADDRESS <u>6500 York Road Baltimore, Md.</u>	

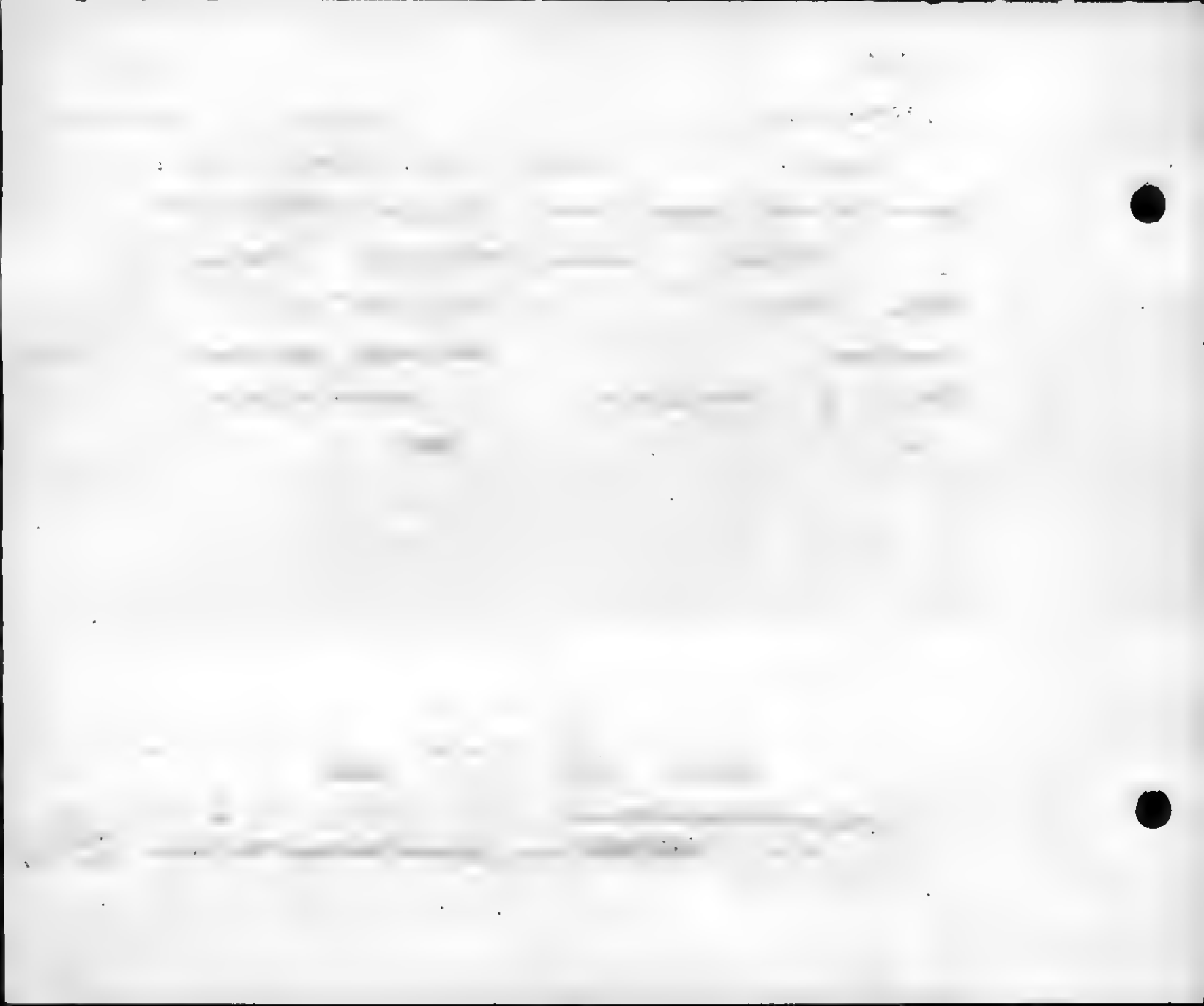


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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01881		Item 3 Film G385		2/16/67		01877					
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN ID 18 HOURS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GLEN ARM, MARYLAND d. STREET ADDRESS Box 660 HARFORD ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First DOROTHY Middle McCarthy Last ELAINE MCCARTHY				4. DATE OF DEATH Month FEBRUARY Day 10 Year 1967							
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-27-1915 51 yrs.		9. AGE (in years last birthday) Months 51 Days 51 Hours 51 Min. 51		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ERNEST E. STANSBURY				14. MOTHER'S MAIDEN NAME ANNA GUYER							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFIRMANT SON		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) RHEUMATIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 6 MOS. 32 + YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 2-9- , 19 67 , to 2-10- , 19 67 , that (I) (we) last saw the deceased alive on 2-10- , 19 67 , and that death occurred at 11:15 AM , from the causes and on the date stated above.											
22a. SIGNATURE <i>E. K. S. Narayanan</i>				M.D. E. K. S. NARAYANAN, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2-10-1967			
22c. PHYSICIAN'S NAME (Type) E. K. S. NARAYANAN, M.D.				22d. ADDRESS GREATER BALTIMORE MED. CENTER, TOWSON, MD. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-13-67		23c. NAME OF CEMETERY OR CREMATORY MORRISLAND MEM. PK. CEM		23d. LOCATION (City, town or county) (State) Bk 110 MD.					
24. FUNERAL DIRECTOR CHAS F. EVANS & SON				ADDRESS 8802 Harford Rd		25a. REC'D BY REGISTRAR DATE FEB 14 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01882

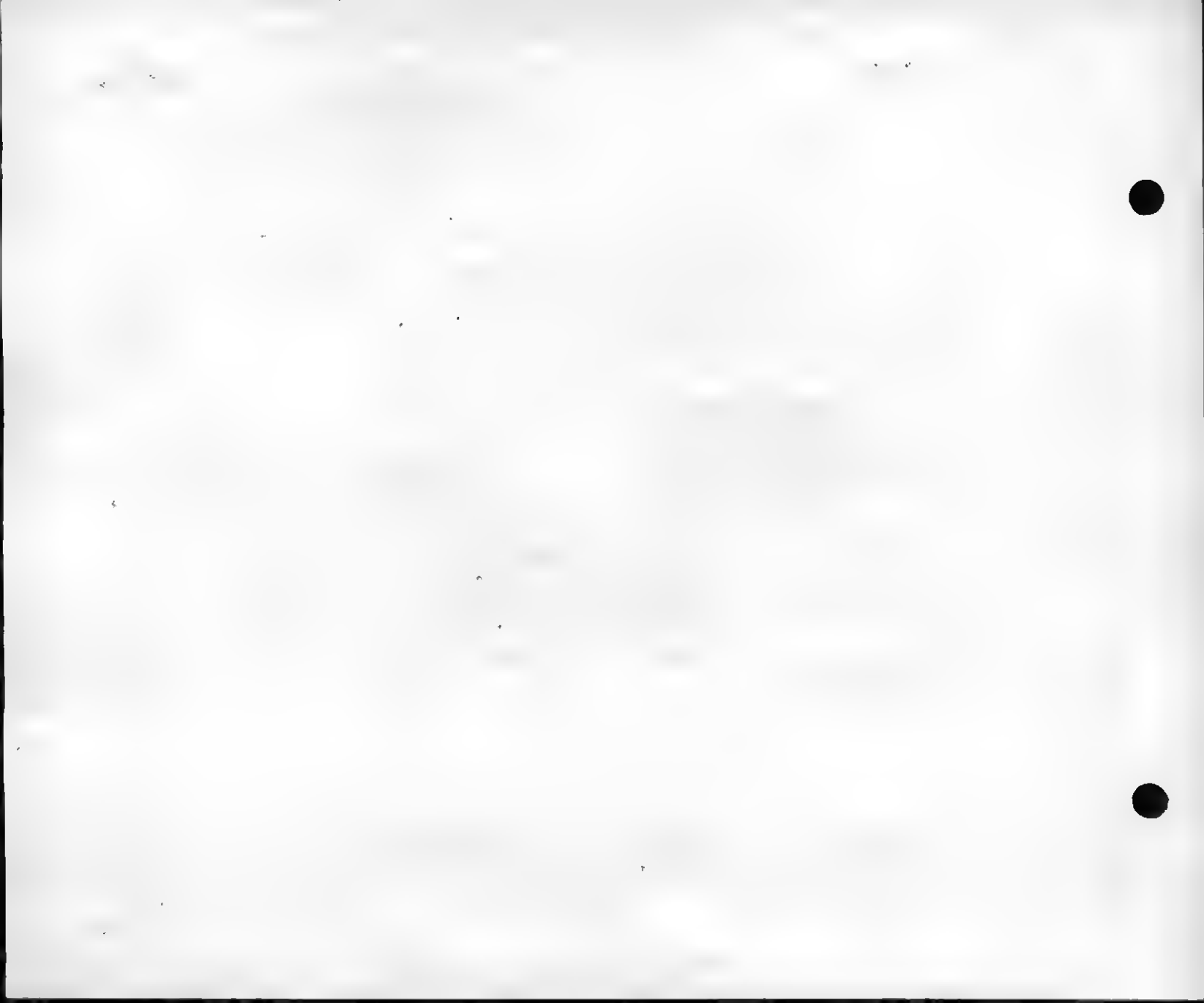
CERTIFICATE OF DEATH

01878

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Baltimore	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		d. STREET ADDRESS 331 Washburn Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Mary Middle T Last McClean		4 DATE OF DEATH Month Feb Day 27 Year 1967	
5 SEX Female	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec 28, 1885
9 AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Md		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hoffmann		14. MOTHER'S MAIDEN NAME Unk	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		Address Same	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Rheumatic Heart Disease with Aortic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) mitral insufficiency of Aortic Valve DUE TO pulmonary disease (c) hypertension			INTERVAL BETWEEN ONSET AND DEATH 10 yrs 50 yrs 6 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/23/67 to 2/27/67 that (I) was last saw the deceased alive on 2/28/67 and that death occurred at 7:00 A M, from causes and on the date stated above.			
22a. SIGNATURE W F McGrath MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2/28/67
22c. PHYSICIAN'S NAME (Type) W F McGrath MD		22d. ADDRESS 1303 Frederick Rd	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 3/2/67	23c NAME OF CEMETERY OR CREMATORY Loudon Park Cem	23d LOCATION (City or Town) (County) (State) Baltimore Md
24 FUNERAL DIRECTOR McCully F H 237 Patapsco Ave 21225		25a REC'D BY REGISTRAR MAR 1 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01883

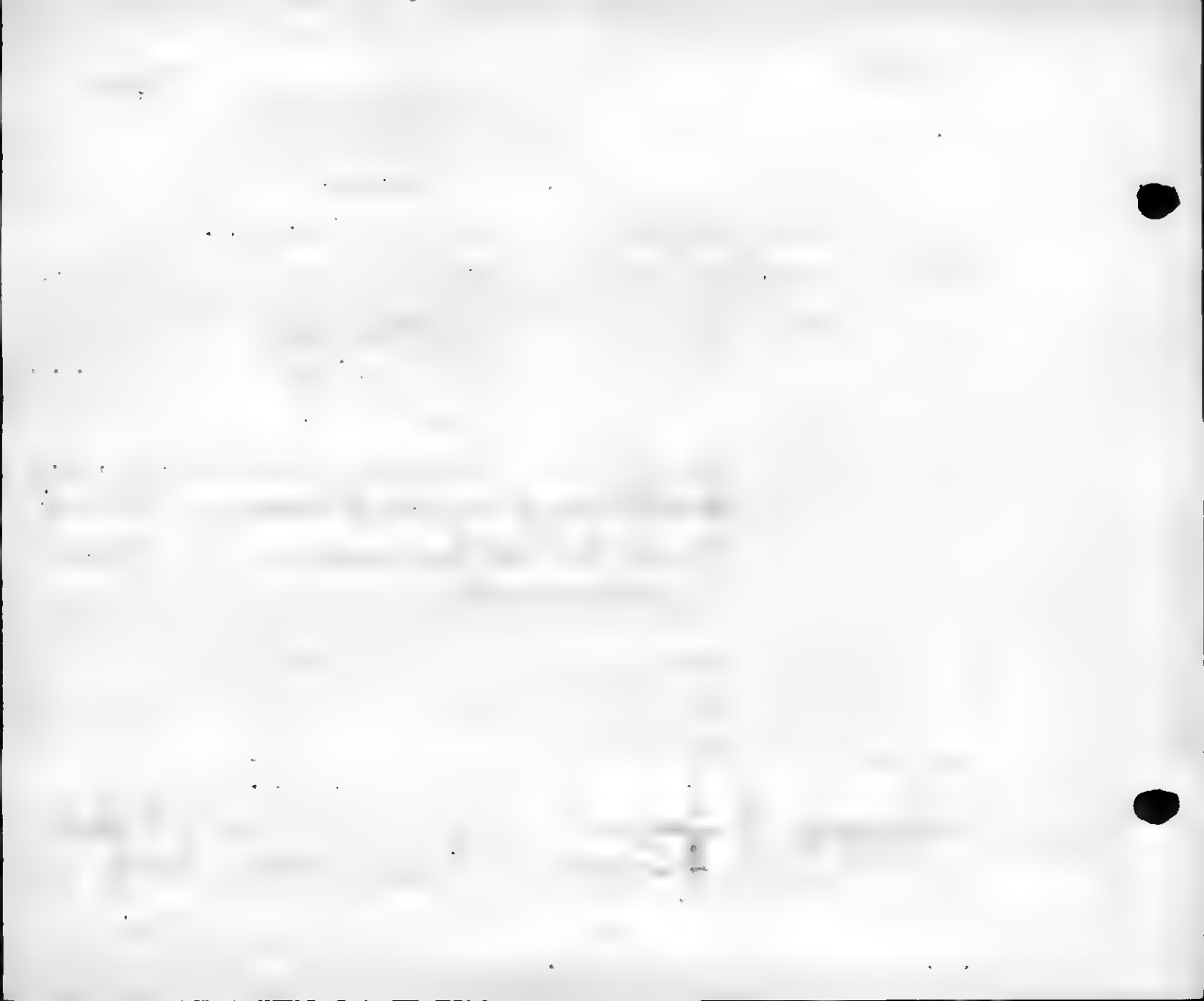
CERTIFICATE OF DEATH

01879

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			c. LENGTH OF STAY IN lb 7 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital				d. STREET ADDRESS 3437 Edmondson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Derrick Leroy McCloud				4. DATE OF DEATH Month Day Year 2 16 19 67				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-20-55		
9. AGE (In years last birthday) 11 yrs.		10. IF UNDER 1 YEAR Months Days		10. IF UNDER 24 HRS Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Osborne				14. MOTHER'S MAIDEN NAME Annette McCloud				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no --		16. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood State Hosp., Owings Mills, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Congestion & edema DUE TO (b) Cerebral edema DUE TO (c) Undetermined							INTERVAL BETWEEN ONSET AND DEATH terminal hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 8-6 , 19 59 , to 2-16 , 19 67 , that (X) (we) last saw the deceased alive on 2-16 , 19 67 , and that death occurred at 10:18 , hours and on the date stated above.								
22a. SIGNATURE Richard A. Jones				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 17 Feb 67		
22c. PHYSICIAN'S NAME (Type) Richard A. Jones				22d. ADDRESS Rosewood State Hosp.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/67		23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		23d. LOCATION (City or Town) (County) (State) Owings Mills, Md.		
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.				25a. REC'D BY REGISTRAR FEB 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

01884

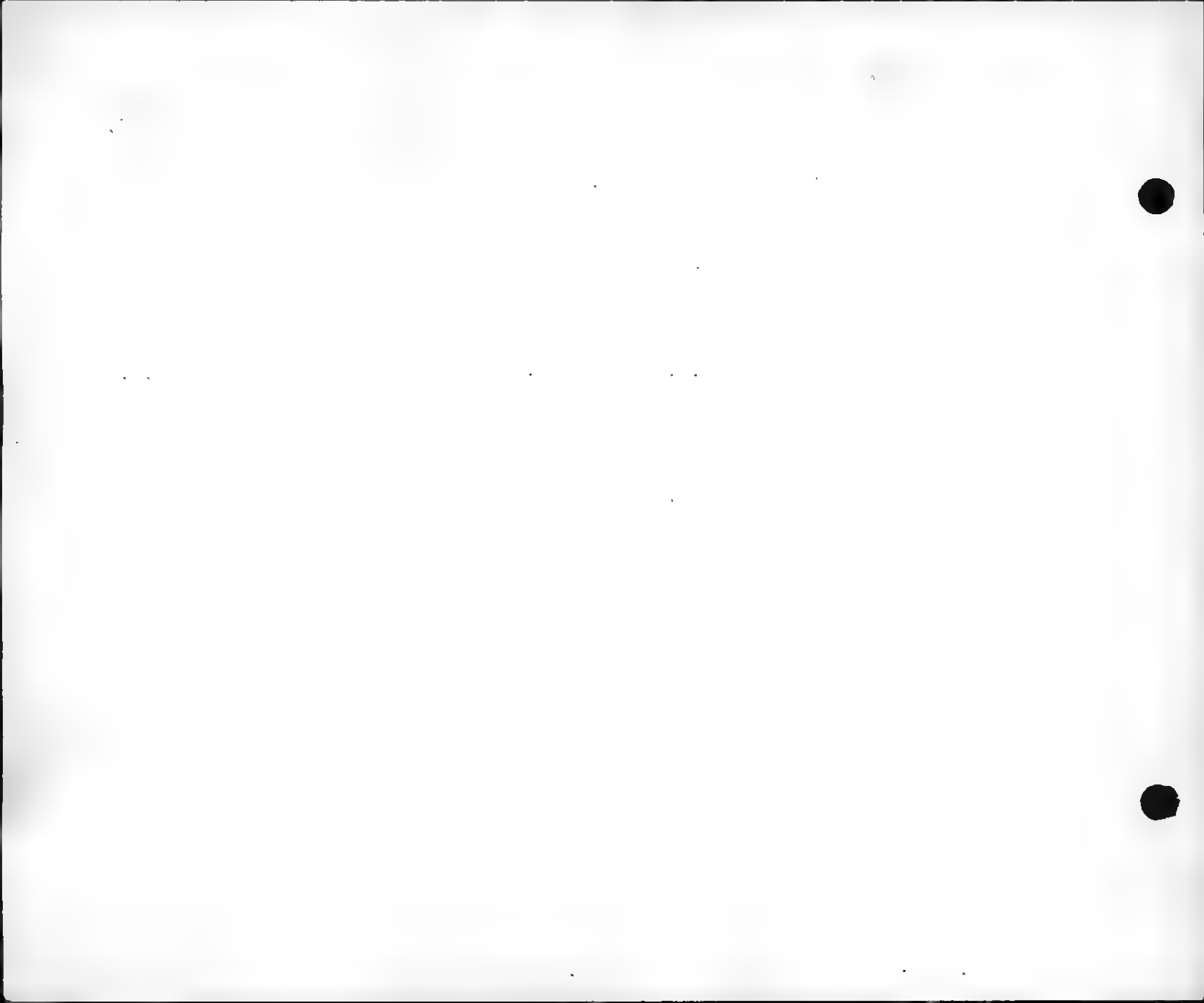
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01880

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution, give name of institution) a STATE MD b COUNTY BALTO.			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Towson			c LENGTH OF STAY IN 1b 2 1/2 yrs			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8200 CARRBRIDGE CIRCLE				d STREET ADDRESS 8200 CARRBRIDGE CI		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN STANLEY McCollough				4 DATE OF DEATH Month FEB Day 1 Year 1967			
5. SEX M	6. CO. OR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-6-24	9 AGE (In years last birthday) 43	10 UNDER 1 YEAR Months 4 Days 3		11 UNDER 24 HRS Hours 3 Min 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager			10b KIND OF BUSINESS OR INDUSTRY A.O. Smith Corp.		11 BIRTHPLACE (State or foreign country) Lancaster Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Huston McCollough				14 MOTHER'S MAIDEN NAME Edythe Johns			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII			16 SOCIAL SECURITY NO 197-07-9173	17 INFORMANT Address Rd. Mrs Julie Stanley McCollough 8200 Carrbridge			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MALIGNANT HYPERTENSION DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 YRS.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)				
20c TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William A. Pillsbury M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY				ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, & county) Timonium, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 2/3/67		23c NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d LOCATION (City or Town) (County) (State) Timonium, Maryland	
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204				25a REC'D BY REGISTRAR EB 6 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in left margin, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MD

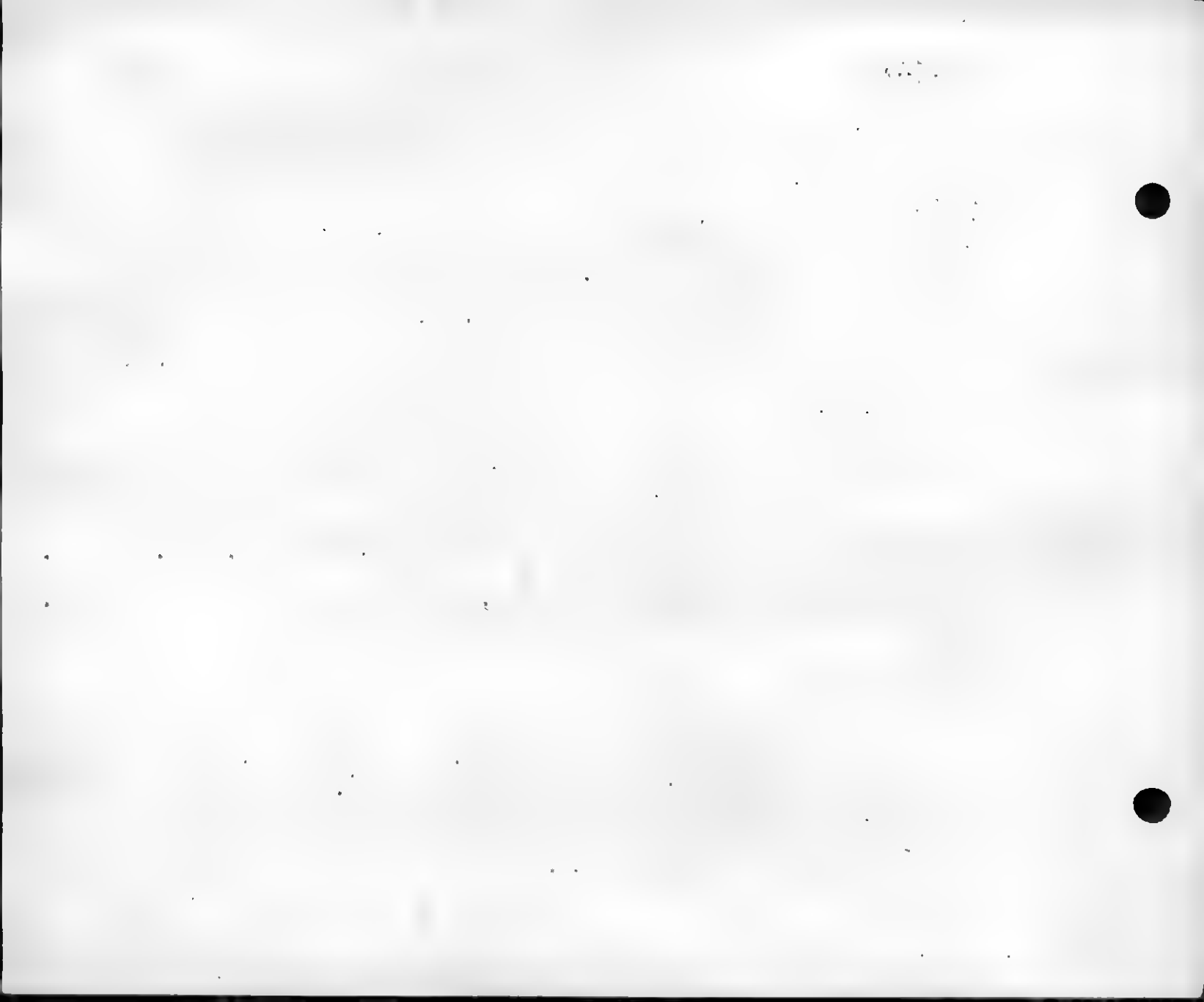
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01885

CERTIFICATE OF DEATH

01881

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN TB 2mthldy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1219 Fayette Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Aldine Middle D. Last McCullough				4. DATE OF DEATH Month February Day 2 Year 1967			
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1897		9. AGE (in years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months — Days — Hours — Min —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Daniel Townsend				14. MOTHER'S MAIDEN NAME Emily			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4-1-11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC CARDIOVASCULAR HT. DIS. 10 yrs. DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED 10 yrs.						INTERVAL BETWEEN ONSET AND DEATH ACUTE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 1, 1966 to Feb. 2, 1967 , that (X) (we) last saw the deceased alive on Feb. 2, 1967 , and that death occurred at 11:00 M, from causes and on the date stated above.							
22a. SIGNATURE <i>Anthony J. Young</i> M.D.				22b. DATE SIGNED Feb. 2, 1967		22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.	
22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Type) Burial		23b. DATE THEREOF 2/9/67		23c. NAME OF CEMETERY OR CREMATORY Auburn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR Adolphus Halstead				25a. REC'D BY REGISTRAR DATE FEB 10 1967		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

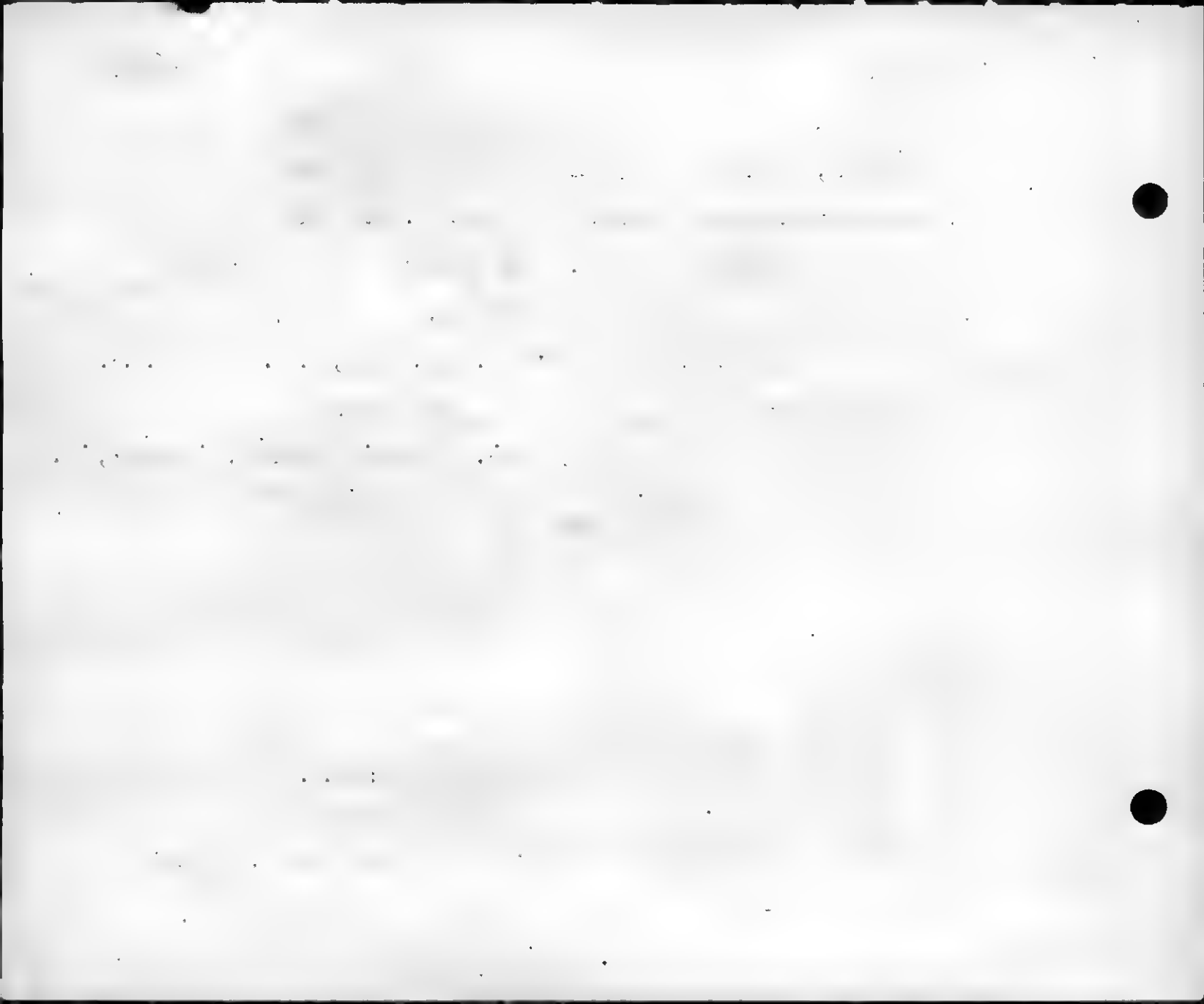
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20M 1/65

01886

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01882

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MARYLAND c. LENGTH OF STAY IN 1b 23 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 804 W. PRATT STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CONLEY Middle W. Last (Mc Gimpsey) MC GIMPSEY				4. DATE OF DEATH Month FEBRUARY Day 5 Year 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 3, 1891 75 Y yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY AMUSEMENT MACHINE CO.		11. BIRTHPLACE (County & State, or foreign country) MORGANTON, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM MC GIMPSEY				14. MOTHER'S MAIDEN NAME ADA CONLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW I		16. SOCIAL SECURITY NO. 217 16 31 05		17. INFORMANT Address Mr. Richard G. Lissau, 504 W. Pratt St. CLIN. RECORDS, VA HOSPITAL, FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA OF RIGHT LUNG WITH METASTASES TO REGIONAL LYMPH NODES DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that 20 (this hospital) attended the deceased from 1/13/67 , 19____, to 2/5/67 , 19____, that (H) (we) last saw the deceased alive on 2/5/67 , 19____, and that death occurred at 4:00 PM from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED 2/7/67		22c. PHYSICIAN'S NAME (Type) SHELDON E. KALMUTZ, M. D.	
22d. ADDRESS VAH FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-9-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town or county) BALTIMORE, MD. (State) _____	
24. FUNERAL DIRECTOR		ADDRESS WITZKE FUNERAL HOME		25a. REC'D BY REGISTRAR 1 FEB 9 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
BALTIMORE, MD.							



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

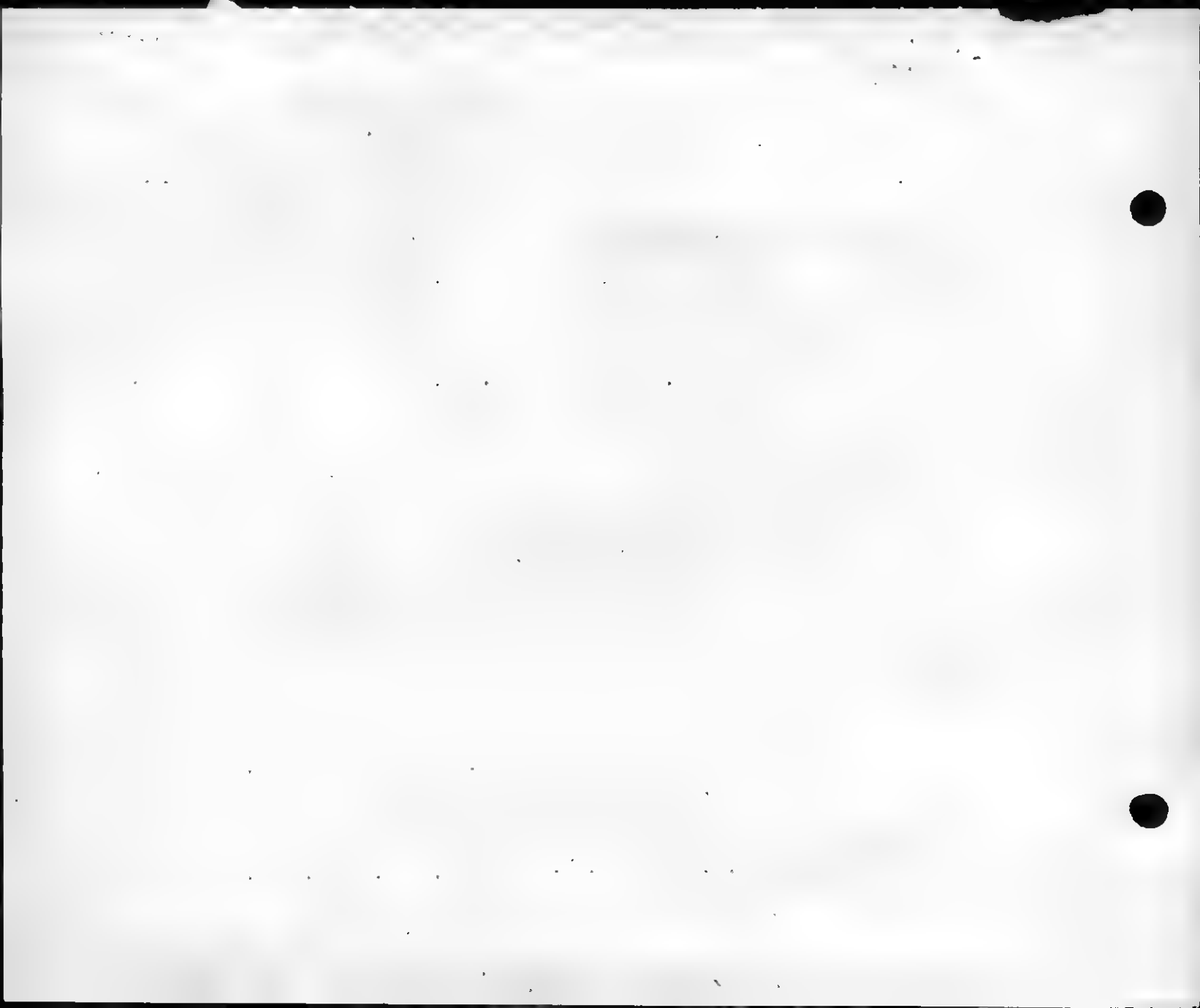
01887

CERTIFICATE OF DEATH

01883

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY in lb 129 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE, # DUNDALK 21222		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3304 CORNWALL ROAD		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ELMER -- MC KENNA				4. DATE OF DEATH FEBRUARY 18 19 67			
5 SEX MALE		6 COLOR OR RACE WHITE		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH DEC. 6, 1914	
9 AGE (In years last birthday) 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Observer- Steel Mfr. Metalurgic		11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH MC KENNA				14. MOTHER'S MAIDEN NAME GERTRUDE LERCH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-11		16. SOCIAL SECURITY NO. 215 03 75 01		17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) METASTATIC CARCINOMA OF GROINS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH DAYS 18 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from OCT. 12 19 66 , to FEB. 18 1967 , that (b) (we) last saw the deceased alive on FEB. 18 1967 , and that death occurred at 1:30 p. M. from causes and on the date stated above							
22a. SIGNATURE <i>Attilio A. Ceraldi</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 2 18 67	
22c. PHYSICIAN'S NAME (Type) ATTILIO A. CERALDI, M. D.				22d. ADDRESS VET. ADM. HOSP., FT. HOWARD, MARYLAND			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/21/67		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Walter Brook Bradley</i> Walter Brook Bradley 400 Willow Spring Rd. Baltimore 22, Md.				25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1- and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01888		01884									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <input checked="" type="checkbox"/>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson - 4</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1195 Welf Street Balto</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balt. Med Center</u>						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) <u>HAROLD</u> <u>NMN</u> <u>McVEY</u>						4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-29-09</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lee McVey</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Hilton</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. <u>400-07-8562</u>		17. INFORMANT <u>Hosp Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Hemoptysis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tracheo-esophageal fistula Cancer Metastasis to liver</u> DUE TO (c) <u>Cancer of the lung, esophagus and trachea</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 6</u> , 1967, to <u>Feb. 17</u> , 1967, that (I) (we) last saw the deceased alive on <u>Feb. 17</u> 1967, and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>C. C. Shih</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>CHU-CHIN SHIH</u>						22d. ADDRESS <u>GREATER BALTIMORE MEDICAL CENTER</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cornett</u>		23d. LOCATION (City, town or county) (State) <u>TOTZ, KY</u>					
24. FUNERAL DIRECTOR <u>Way Dickson & Sons 1101 W. Balto. Med.</u>						25a. REC'D BY REGISTRAR <u>FEB 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

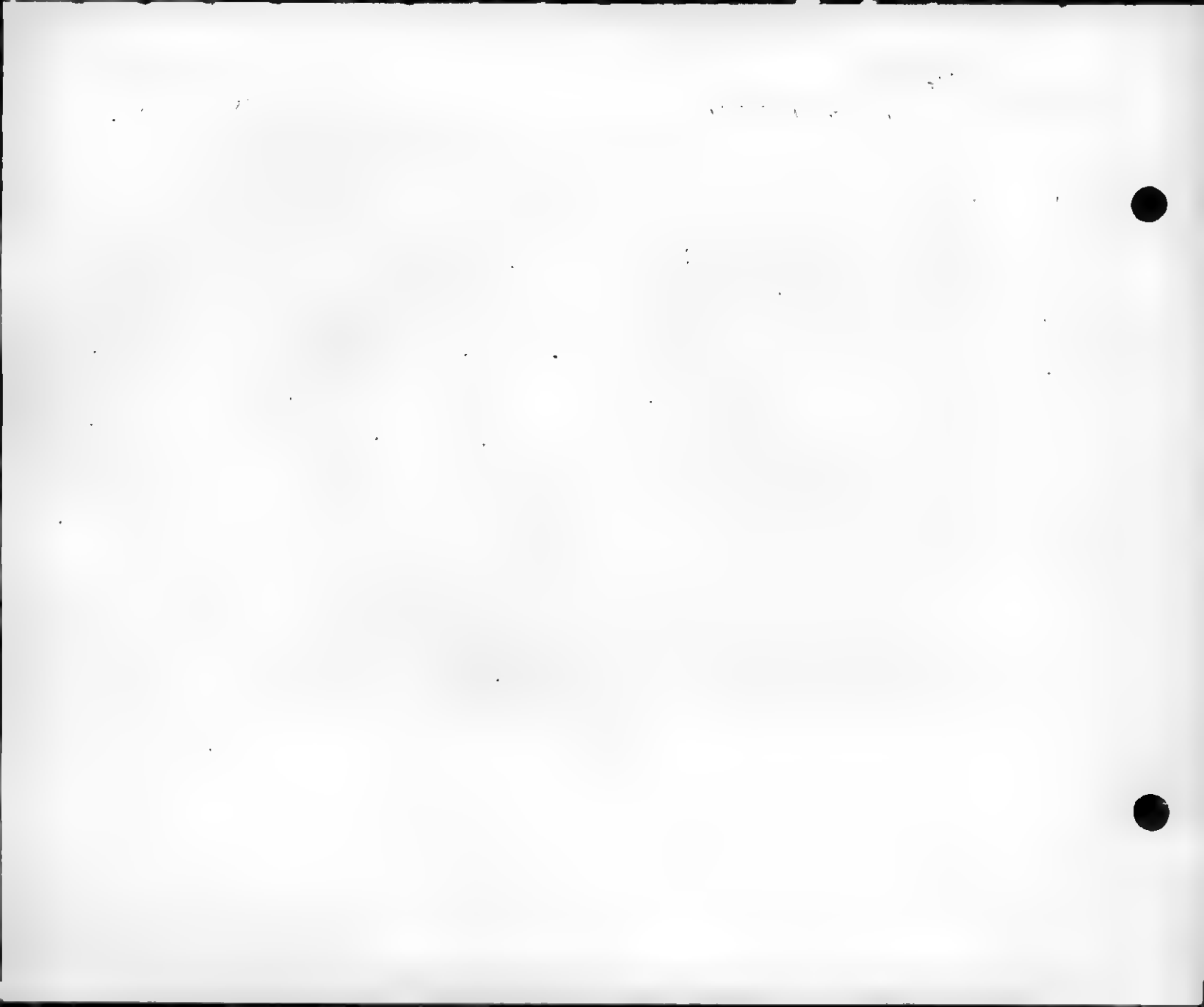
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01889

01885

1. PLACE OF DEATH a. COUNTY 8549 MORVIN RD. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE - Parkville			
c. LENGTH OF STAY IN 1b 6 YEARS				d. STREET ADDRESS 8549 MORVIN ROAD			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8549 MORVIN RD., BALTO., MD.							
3. NAME OF DECEASED (Type or print) First Middle Last MARY PATRICIA MEGEE				4. DATE OF DEATH Month Day Year FEB. 9th 1967			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/10/21	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE.				10b. KIND OF BUSINESS OR INDUSTRY NONE.		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME MR. RICHARD LEONARD				14. MOTHER'S MAIDEN NAME MRS. MARGARET FINNEGAN.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE.		17. INFORMANT MR. GEORGE MEGEE		Address (SAME AS ABOVE)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF THE LIVER. DUE TO (b)) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EPILEPSY							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. NONE. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) NONE.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959, 19 to FEB. 9, 1967, that (I) (we) last saw the deceased alive on FEB. 9, 1967, and that death occurred at 2:25 AM from the causes and on the date stated above.							
22a. SIGNATURE Ruben Sebastian				22b. DATE SIGNED 2/9/67			
22c. PHYSICIAN'S NAME (Type) RUBEN S. SEBASTIAN				22d. ADDRESS 3098A OLD HARFORD RD. #34			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 13 1967		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		23d. LOCATION (City, town or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR J. Melville Jenkins 2713 Kirk Ave				25a. REC'D BY REGISTRAR FEB 14 1967			
25b. REGISTRAR'S SIGNATURE J. Melville Jenkins							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. Page 2 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

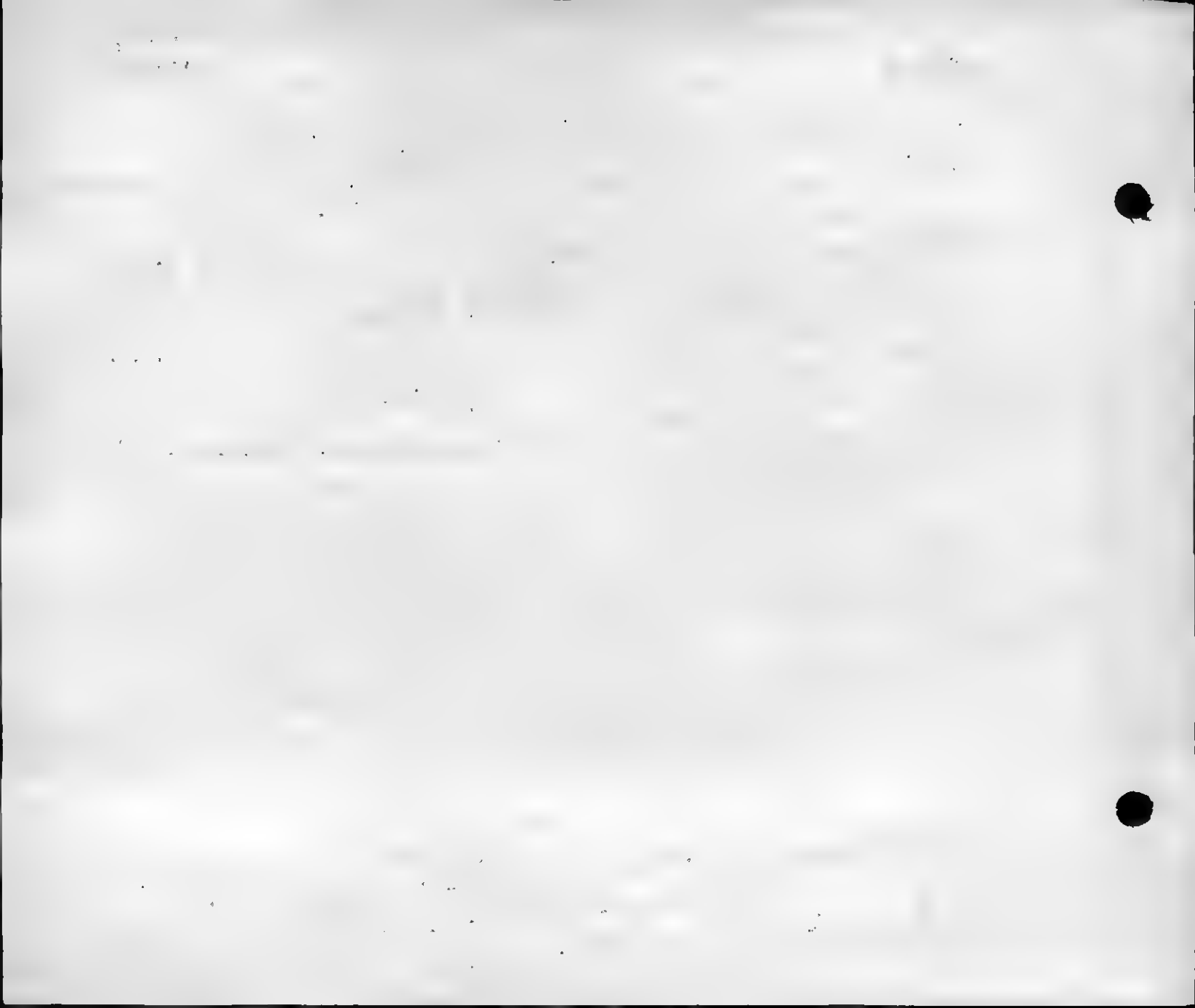
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01890

01886

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middle River		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ivy Hall Nursing Home		d. STREET ADDRESS 1307 Gorsuch Ave.	
3. NAME OF DECEASED (Type or print) Cora E. Menzel		4. DATE OF DEATH Month February , Day 2 , Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 73 IF UNDER 1 YEAR: Months 7 , Days 3 IF UNDER 24 HRS: Hours 7 , Min. 3
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Conrad Hohman		14. MOTHER'S MAIDEN NAME Cornelia Speigel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Virginia Riggins, 2 Branch St. 21221		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 1992 DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma of ovary + col (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/7 , 19 66 , to 2/2 , 19 67 , that (I) (we) last saw the deceased alive on 1/28 , 19 67 , and that death occurred at 4 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Samuel Stern		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Samuel Stern M.D.		22d. ADDRESS 285 Ridge Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ulrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR FLB 6 1967 DATE	
		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01891

CERTIFICATE OF DEATH

01887

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN TB		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>21212</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. STREET ADDRESS <u>8014 Wynbrook Rd.</u> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Kay Yvonne Meredith</u> First Middle Last		4. DATE OF DEATH <u>FEB. 20 19 67</u> Month Day Year	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>CAUC.</u>	7 MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-13-35</u> 9 AGE (In years past birthday) <u>31</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE CLERK - HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>SHAMOKIN, PA.</u>		12 CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>WILLIAM FRANCIS LYTLE</u>		14 MOTHER'S MAIDEN NAME <u>DOROTHY M AYKOR</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>161-28-9894</u>	
17 INFORMANT <u>MASSIE PONTINE KEMMERHAGE</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Chronic Hypertension</u> DUE TO (c) <u>13 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>Oct 1966</u> , to <u>Feb 20 1967</u> , that (1) (we) last saw the deceased alive on <u>Feb 20 1967</u> , and that death occurred at <u>6:45 P.M.</u> from causes on and on the date stated above			
22a. SIGNATURE <u>Clifton C. Presser</u>		22b. DATE SIGNED <u>2/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Clifton C. Presser</u>		22d. ADDRESS <u>GREATER BALTO. MED. CENTER 101 W. Reed St.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Rem. Burial</u>	<u>2/24/1967</u>	<u>Odd Fellows</u>	<u>Shamokin, Pa.</u>
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>		25a. REC'D BY REG. STRAR <u>FEB 23 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01892

Item #6 Film #331-2/7/67

CERTIFICATE OF DEATH

01888

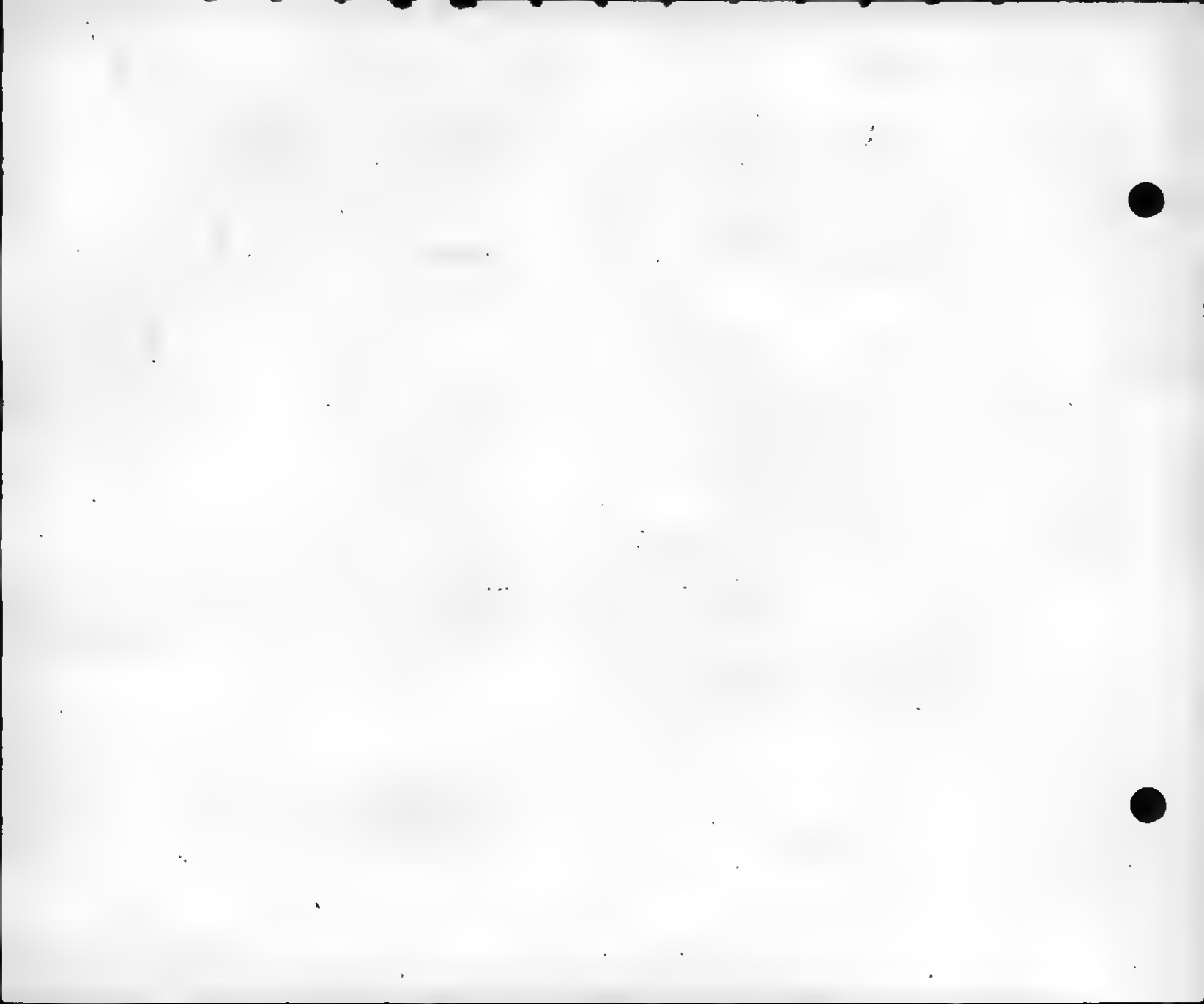
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 20204			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 617 Charles St.			
3. NAME OF DECEASED (Type or print) First Alice Middle MERRITT Last MERRITT				4. DATE OF DEATH Month February Day 11 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1889	9. AGE (In years lost birthday) yrs. 77	IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min 77		IF UNDER 24 HRS. Hours 77 Min 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4XCI DUE TO Acute myocardial infarction secondary to coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerosis (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that MD (this hospital) attended the deceased from 2/6/ , 19 67 , to 2/11/ , 19 67 that MD (we) last saw the deceased alive on 2/11/ , 19 67 , and that death occurred at 12:30M , from causes and on the date stated above.							
22a. SIGNATURE Arturo A. Pidlaoan MD			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED February 11, 1967		
22c. PHYSICIAN'S NAME (Type) Arturo Pidlaoan, M.D.			22d. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-13-67		23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		23d. LOCATION (City or town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR			ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 14 1967		25b. REGISTRAR'S SIGNATURE [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

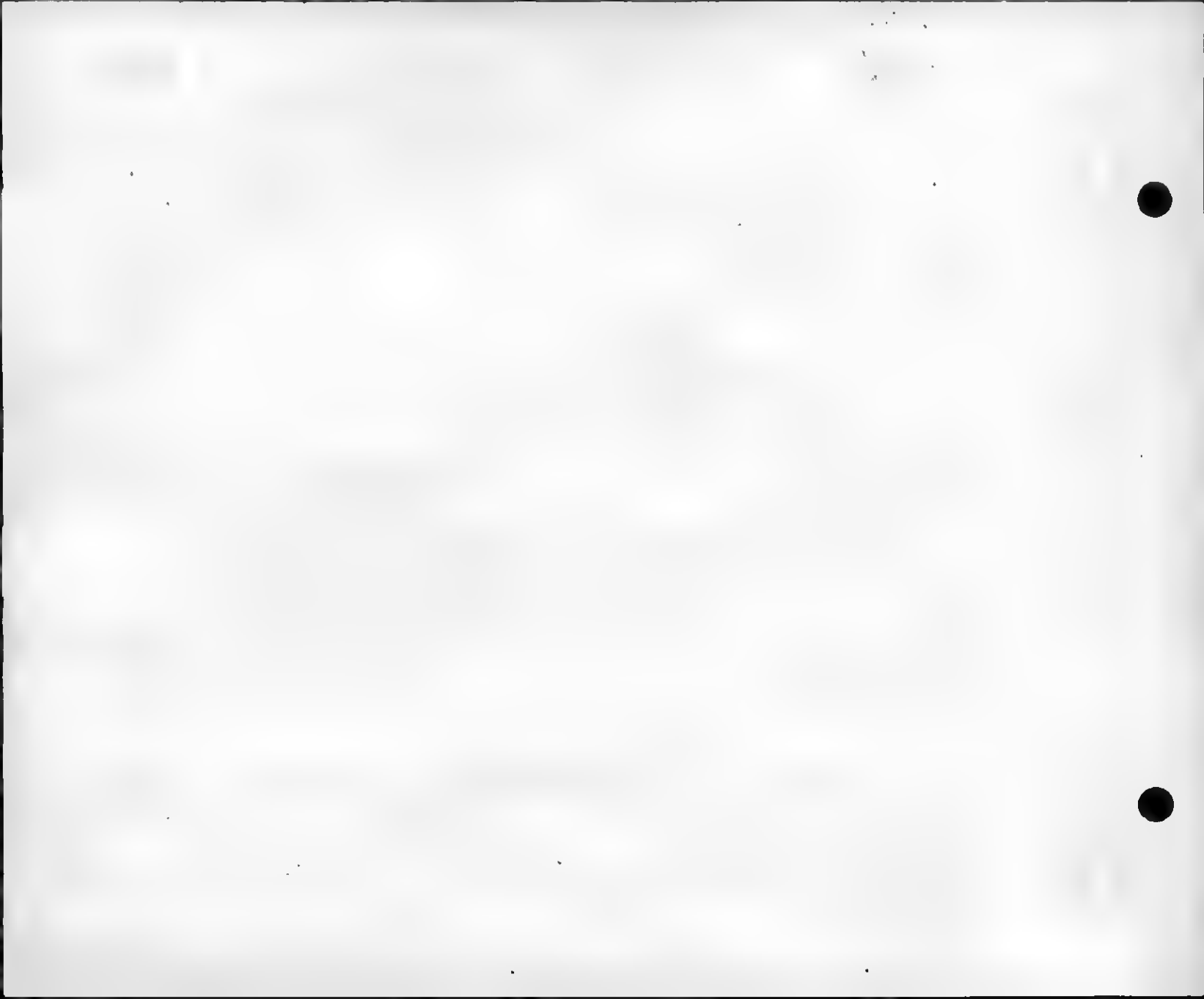
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01893						01893					
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dulaney Towson Home c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dulaney Towson Home						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY AA Co c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS Ft Smallwood Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John Thomes Metzdorf First Middle Last						4. DATE OF DEATH Feb 20 1967 19 Month Day Year					
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/13/87		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sea Food				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unk						14. MOTHER'S MAIDEN NAME Mary Conaway					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Family			Address Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Arteriosclerotic C-V disease DUE TO (c) CH of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 2/13 , 1967, to Feb. 20 , 1967, that (I) (we) last saw the deceased alive on Feb. 19 , 1967, and that death occurred at 1:19 PM , from the causes and on the date stated above.											
22a. SIGNATURE Tos. A. Sedlack						22b. DATE SIGNED 2/21/67					
22c. PHYSICIAN'S NAME (Type) Tos. A. Sedlack						22d. ADDRESS 260 W. Preston Ave Towson Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/22/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) AA CO Md		24. FUNERAL DIRECTOR ADDRESS McCully F H 237 Patapsco Ave 21225	
25a. REC'D BY REGISTRAR FEB 23 1967						25b. REGISTRAR'S SIGNATURE William J. Under					



23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/5/67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	23d. LOCATION (City or Town) (County) (State) A.A.Co. Maryland
24. FUNERAL DIRECTOR William E. Johnson	ADDRESS 521 Loch Haven Blvd.		25a. REC'D BY REGISTRAR DATE FEB 14 1967
		25b. REGISTRAR'S SIGNATURE Charles Judge	

VR A15 (4)
20 M 1/66



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #12 Film #1111 DC

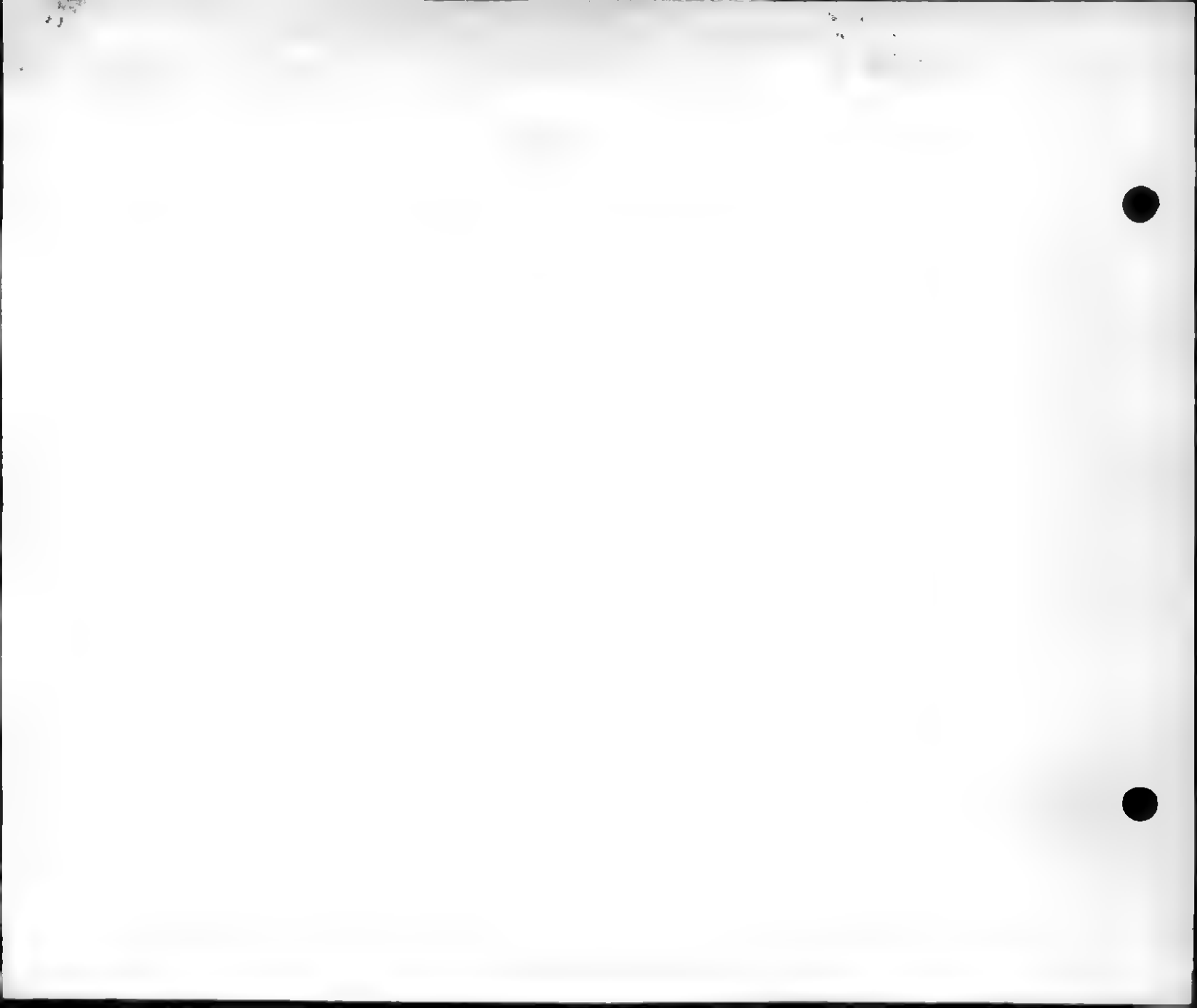
01895

CERTIFICATE OF DEATH

01891

1. NAME OF DECEASED (Type or Print) Ilona Mihalovich		2. DATE AND HOUR OF DEATH 2-1-67 12:10am	
3. PLACE OF DEATH IN MARYLAND Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore, Maryland D. STREET ADDRESS (If rural, give location) 627 Aldershot Road	
5. SEX Female		6. RACE White	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 3-13-95	
9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Editorial assistant Newspaper	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? Hungary	
13. FATHER'S NAME Carl Helmbold		14. MOTHER'S MAIDEN NAME Helene Albach	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-48-0044	
17. INFORMANT Rajkay Alice Rajkay		ADDRESS 627 Aldershot Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.) Metastatic melanoma, 2 1/2 yrs. previously, in situ.		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. CAUSE OF DEATH A. DUE TO B. DUE TO C. DUE TO	
21. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22. HOW DID INJURY OCCUR While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
23. I certify that (I) (this hospital) attended the deceased from 1-28-67 to 1-28-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		24. DATE SIGNED 2-1-67	
25. SIGNATURE George C. Roveti		26. DATE Feb. 2, 1967	
27. NAME OF CEMETERY or CREMATORY New Cathedral Cem.		28. LOCATION Balto. Md.	
29. DATE REC'D BY HEALTH DEPT. FEB 9 1967		30. NAME OF REGISTRAR Charles J. Jones	
31. FUNERAL DIRECTOR G. Truman Schwab		ADDRESS 3512 Frederick Ave., Balto. Md.	

VR A15 (4)
25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01896

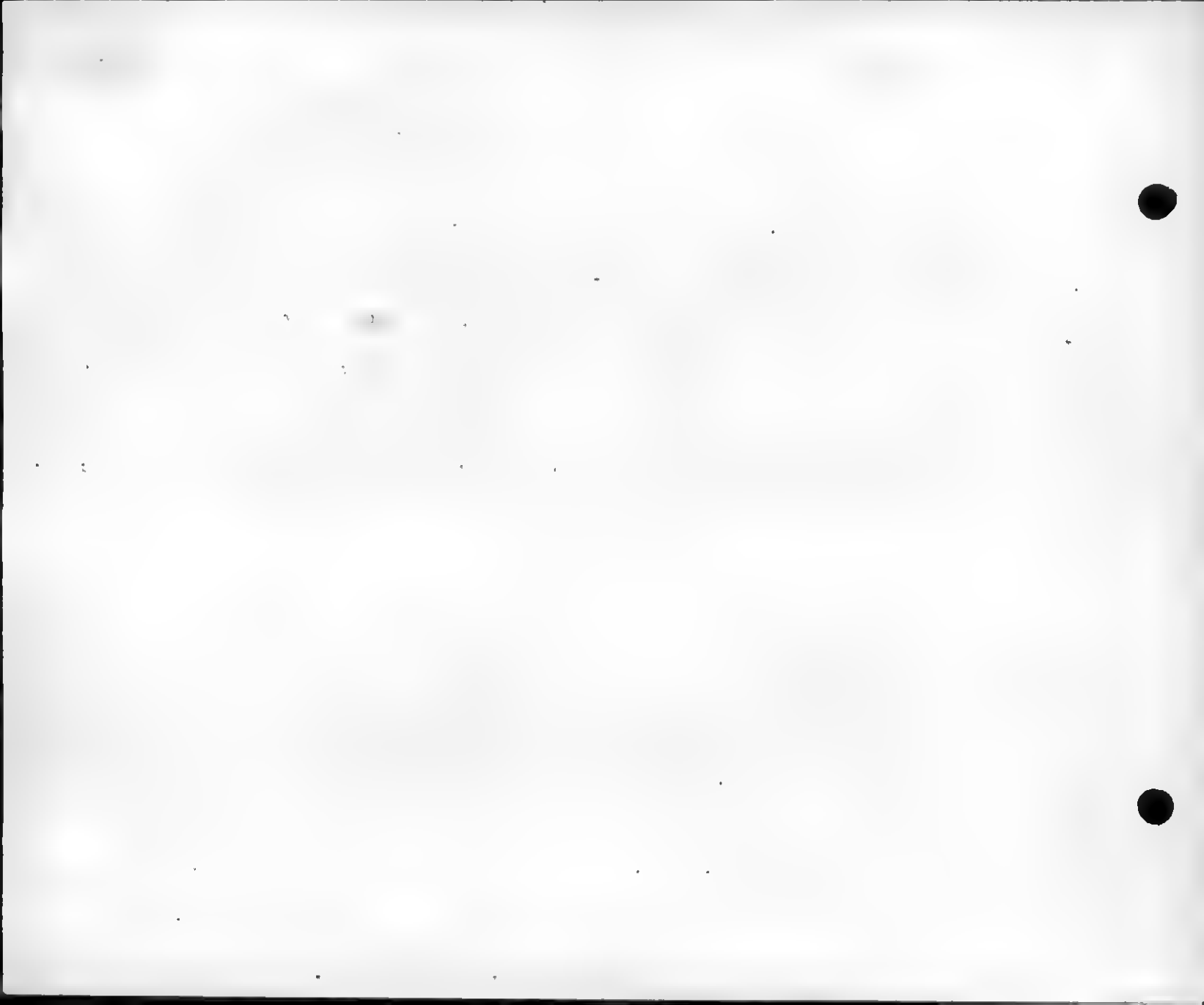
CERTIFICATE OF DEATH

01892

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 690 DAYS		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1639 NORTH BENTALOU STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First GEORGE Middle HENRY Last MILES		4 DATE OF DEATH Month FEBRUARY Day 14 Year 19 67		5 SEX MALE 6 COLOR OR RACE NEGRO 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH DEC. 25, 1896 9 AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR Months 14 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work on life even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY PRIVATE FAMILY		11 BIRTHPLACE (County & State, or foreign country) DEALS ISLAND, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE MILES				14. MOTHER'S MAIDEN NAME ELLA WALLACE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 216 01 88 71		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO CEREBRAL THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS (c)						INTERVAL BETWEEN ONSET AND DEATH RECENT	
						MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MALNUTRITION						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/24/67 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/14/67 , 19 67 , and that death occurred at 6:40A M. from causes and on the date stated above.							
22a. SIGNATURE <i>George Dudas</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/15/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL CREMATION, REMOVA. (Specify) BURIAL		23b. DATE THEREOF 2-17-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR MORTEN & DYETT FUNERAL HOME 1701 Laurens St. Baltimore, Md.				25a. RECEIVED BY REGISTRAR DATE 3-23-1967		25b. REGISTRAR'S SIGNATURE	

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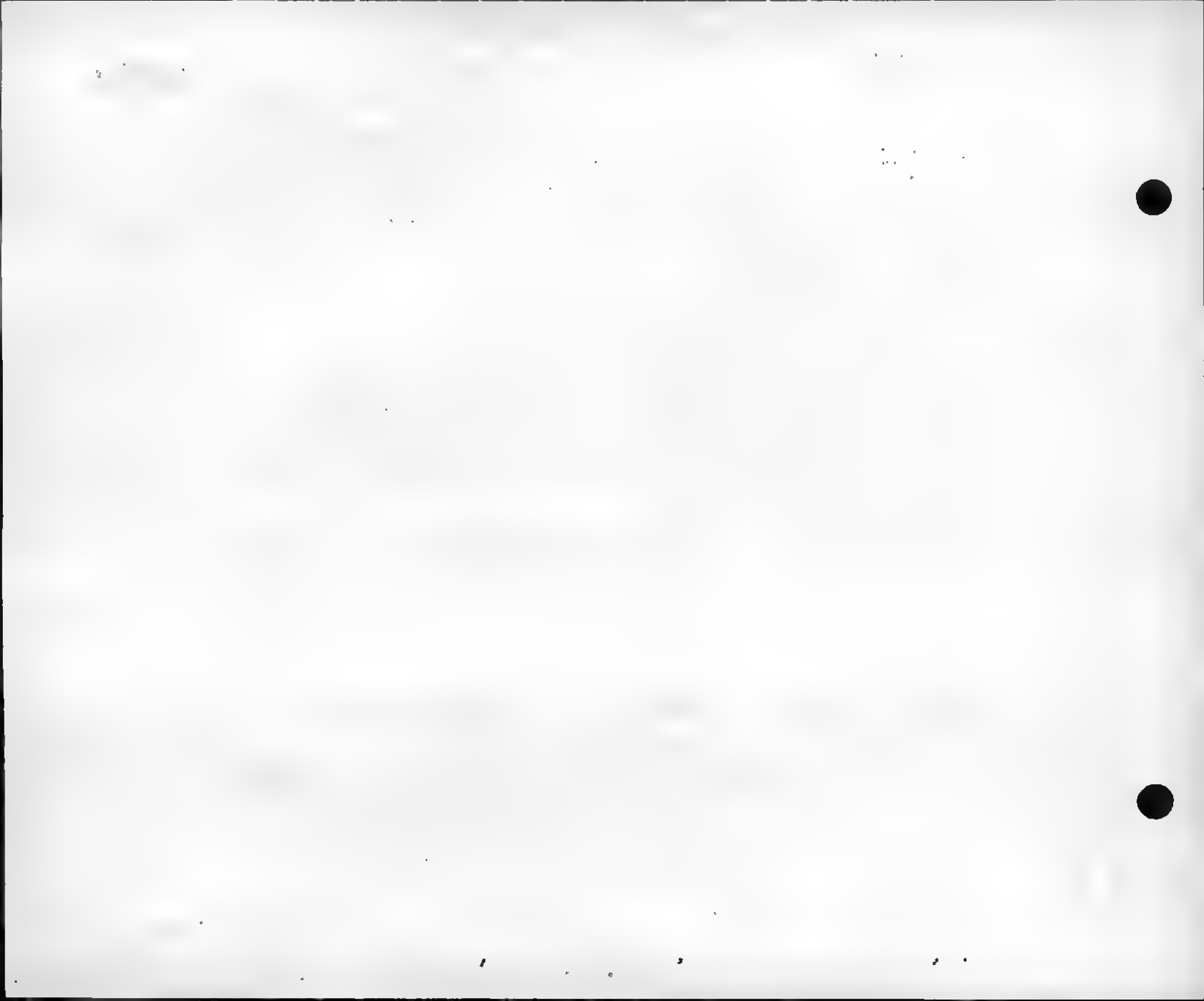
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01897

CERTIFICATE OF DEATH

01893

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARFISON LUTHERVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Gen. Hosp</u>				d. STREET ADDRESS <u>FALLS ROAD</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>L.</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/1880</u>	9. AGE (In years last birthday) <u>87</u> yrs	F UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lanahan, CHARLES M.</u>				14. MOTHER'S MAIDEN NAME <u>Snowden, ANNA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv co) <u>no</u>		16. SOCIAL SECURITY NO <u>216-56-8078</u>		17. INFORMANT <u>W. MILES CARY, JR.</u> <u>(Chart) FALLS ROAD, LUTHERVILLE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>443A</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u> </u> DUE TO (c) <u> </u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <u>this hospital</u> attended the deceased from <u>2/5/67</u> , 19 <u> </u> , to <u>2/10/67</u> , 19 <u> </u> , that (1) <u>we</u> last saw the deceased alive on <u>2/10/67</u> , 19 <u> </u> , and that death occurred at <u>7A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Rafael Perez-Mera</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>2/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. RAFAEL PEREZ-MERA</u>				22d. ADDRESS <u>BALTO. COUNTY GENERAL HOSP.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2/11/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>				25a. REC'D BY REGISTRAR <u>1905 York Rd.</u> <u>Balto. 12, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>FEB 11 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01898

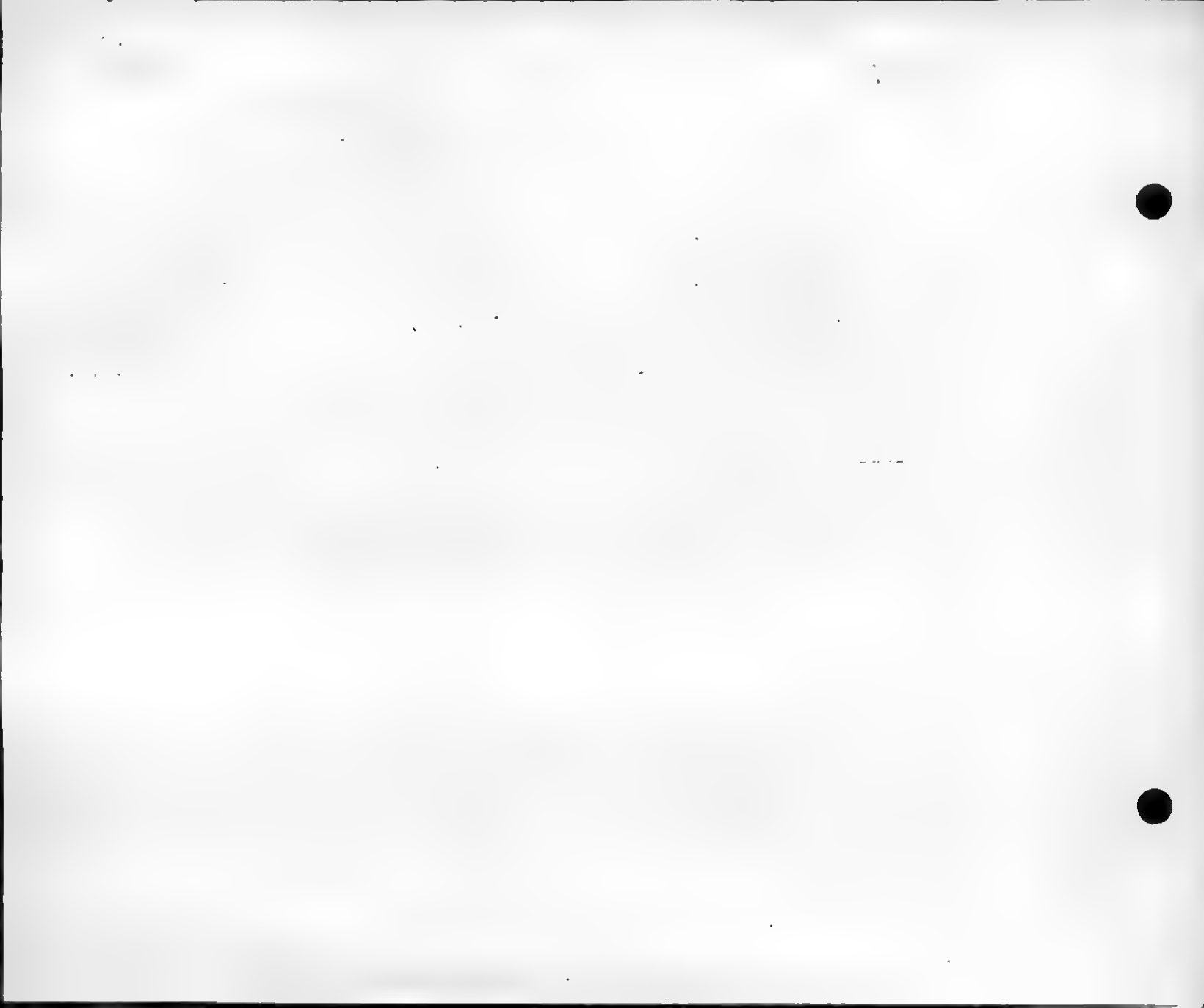
CERTIFICATE OF DEATH

01894

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c LENGTH OF STAY IN 1b Lutherville	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 130 Tenbury Rd.		d. STREET ADDRESS 130 Tenbury Road	
3 NAME OF DECEASED (Type or print) First Middle Last Harry J. Mohr		4 DATE OF DEATH Month Day Year Feb. 17, 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH Aug. 10, 1885
9 AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner of Meat Store		10b KIND OF BUSINESS OR INDUSTRY Meat	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Mohr		14. MOTHER'S MAIDEN NAME Margaret Lehmuth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-5627	
17. INFORMANT Mabel R. Mohr, Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GENERALIZED METASTATIC CANCER 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF SIGMOID AND BLADDER DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASCVD WITH CONGESTIVE FAILURE			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT 20, 1966 to FEB 17, 1967 , that (I) (we) last saw the deceased alive on FEB 14, 1967 , and that death occurred at 12:35 M, from causes and on the date stated above.			
22a SIGNATURE T. C. Siwinski		22b DATE SIGNED 2/18/67	
22c PHYSICIAN'S NAME (Type) T. C. SIWINSKI		22d ADDRESS 206 W. PENNA. AVE TOWSON, Md	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Feb. 20, 1967	23c NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	23d. LOCATION (City or Town) (County) (State) Woodlawn, Md.
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road, Towson, Md. 21204		25a REC'D BY REGISTRAR FEB 20 1967	
		25b REGISTRAR'S SIGNATURE Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

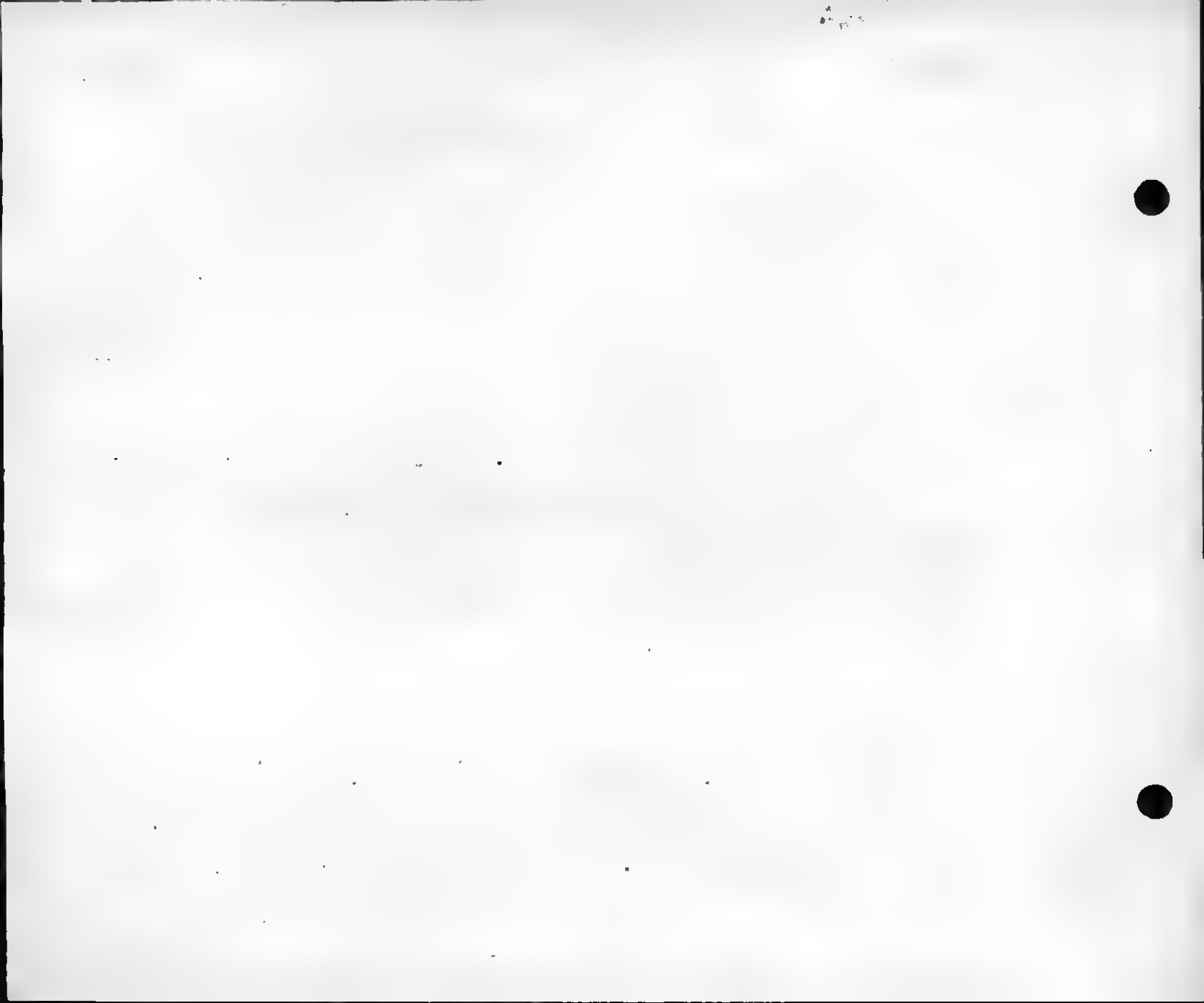
01899

CERTIFICATE OF DEATH

01895

1. PLACE OF DEATH a COUNTY Baltimore MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c LENGTH OF STAY in 1b d NAME OF HOSPITAL OR INSTITUTION (If not in hosp'to., give street address) St. Joseph Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Virginia b COUNTY c CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Fairfax d STREET ADDRESS 4541 McKenzie Avenue e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last John Howard Moore				4. DATE OF DEATH Month Day Year Feb. 1 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-15-99		9. AGE (In years last birthday) 67 yrs 10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Moore				14. MOTHER'S MAIDEN NAME Selma Sexton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 227-18-5539		17. INFORMANT Address Mrs. Pauline Burkholder; Fairfax, Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia extensive, right lung (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old myocardial infarctions.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that MO (this hospital) attended the deceased from Jan. 3 rd, 1967, to Feb. 1 st, 1967 , that MO (we) last saw the deceased alive on Feb. 1 st 19 67 , and that death occurred at 3:20 M. from causes and on the date stated above.									
22a. SIGNATURE 						22b. DATE SIGNED Feb. 1 st 1967			
22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.						22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/5/67		23c. NAME OF CEMETERY OR CREMATORY Moore Family Cemetery			23d. LOCATION (City or Town) (County) (State) Del Rio, Tenn.	
24. FUNERAL DIRECTOR Everly Funeral Home ADDRESS By Mgr. Fairfax, Virginia						25a. REC'D BY REGISTRAR DATE FEB 3 1967		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR AIS 14
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01900 Item #2 a, b, c & d 01897											
1. PLACE OF DEATH a. COUNTY Baltimore				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b MARYLAND			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House-in-the-Pines - Catonsville				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland W. Va. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS Route #12 17 Fustling Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Murlan				4. DATE OF DEATH Last Moran Month February Day 28 Year 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7/20/1900		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner				10b. KIND OF BUSINESS OR INDUSTRY West Virginia				11. BIRTHPLACE (County & State, or foreign country) West Virginia			
12. CITIZEN OF WHAT COUNTRY? West Virginia				13. FATHER'S NAME Elijah Moran				14. MOTHER'S MAIDEN NAME Mollie Harbert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. World War I				17. INFORMANT House in the Pines - Catonsville Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac arrest DUE TO (b) Chronic myocarditis DUE TO (c) Chronic myocarditis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State) 20i. (City or town) (County) (State) 20j. (City or town) (County) (State) 20k. (City or town) (County) (State) 20l. (City or town) (County) (State) 20m. (City or town) (County) (State) 20n. (City or town) (County) (State) 20o. (City or town) (County) (State) 20p. (City or town) (County) (State) 20q. (City or town) (County) (State) 20r. (City or town) (County) (State) 20s. (City or town) (County) (State) 20t. (City or town) (County) (State) 20u. (City or town) (County) (State) 20v. (City or town) (County) (State) 20w. (City or town) (County) (State) 20x. (City or town) (County) (State) 20y. (City or town) (County) (State) 20z. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 8-23-1966 to 2-28-1967 that (I) (we) last saw the deceased alive on 2-27-1967 and that death occurred at 2 PM from the causes and on the date stated above. 22a. SIGNATURE Wilmer K. Gallager Sr. M.D. 22b. DATE 3-2-67 22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallager Sr. 22d. ADDRESS 6209 Frederick Ave Baltimore 28 Md. 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. DATE 3-2-67 22g. SIGNATURE Charles Judge 22h. DATE 3-2-67 22i. SIGNATURE Charles Judge 22j. DATE 3-2-67 22k. SIGNATURE Charles Judge 22l. DATE 3-2-67 22m. SIGNATURE Charles Judge 22n. DATE 3-2-67 22o. SIGNATURE Charles Judge 22p. DATE 3-2-67 22q. SIGNATURE Charles Judge 22r. DATE 3-2-67 22s. SIGNATURE Charles Judge 22t. DATE 3-2-67 22u. SIGNATURE Charles Judge 22v. DATE 3-2-67 22w. SIGNATURE Charles Judge 22x. DATE 3-2-67 22y. SIGNATURE Charles Judge 22z. DATE 3-2-67 22aa. SIGNATURE Charles Judge 22ab. DATE 3-2-67 22ac. SIGNATURE Charles Judge 22ad. DATE 3-2-67 22ae. SIGNATURE Charles Judge 22af. DATE 3-2-67 22ag. SIGNATURE Charles Judge 22ah. DATE 3-2-67 22ai. SIGNATURE Charles Judge 22aj. DATE 3-2-67 22ak. SIGNATURE Charles Judge 22al. DATE 3-2-67 22am. SIGNATURE Charles Judge 22an. DATE 3-2-67 22ao. SIGNATURE Charles Judge 22ap. DATE 3-2-67 22aq. SIGNATURE Charles Judge 22ar. DATE 3-2-67 22as. SIGNATURE Charles Judge 22at. DATE 3-2-67 22au. SIGNATURE Charles Judge 22av. DATE 3-2-67 22aw. SIGNATURE Charles Judge 22ax. DATE 3-2-67 22ay. SIGNATURE Charles Judge 22az. DATE 3-2-67 22ba. SIGNATURE Charles Judge 22bb. DATE 3-2-67 22bc. SIGNATURE Charles Judge 22bd. DATE 3-2-67 22be. SIGNATURE Charles Judge 22bf. DATE 3-2-67 22bg. SIGNATURE Charles Judge 22bh. DATE 3-2-67 22bi. SIGNATURE Charles Judge 22bj. DATE 3-2-67 22bk. SIGNATURE Charles Judge 22bl. DATE 3-2-67 22bm. SIGNATURE Charles Judge 22bn. DATE 3-2-67 22bo. SIGNATURE Charles Judge 22bp. DATE 3-2-67 22bq. SIGNATURE Charles Judge 22br. DATE 3-2-67 22bs. SIGNATURE Charles Judge 22bt. DATE 3-2-67 22bu. SIGNATURE Charles Judge 22bv. DATE 3-2-67 22bw. SIGNATURE Charles Judge 22bx. DATE 3-2-67 22by. SIGNATURE Charles Judge 22bz. DATE 3-2-67 22ca. SIGNATURE Charles Judge 22cb. DATE 3-2-67 22cc. SIGNATURE Charles Judge 22cd. DATE 3-2-67 22ce. SIGNATURE Charles Judge 22cf. DATE 3-2-67 22cg. SIGNATURE Charles Judge 22ch. DATE 3-2-67 22ci. SIGNATURE Charles Judge 22cj. DATE 3-2-67 22ck. SIGNATURE Charles Judge 22cl. DATE 3-2-67 22cm. SIGNATURE Charles Judge 22cn. DATE 3-2-67 22co. SIGNATURE Charles Judge 22cp. DATE 3-2-67 22cq. SIGNATURE Charles Judge 22cr. DATE 3-2-67 22cs. SIGNATURE Charles Judge 22ct. DATE 3-2-67 22cu. SIGNATURE Charles Judge 22cv. DATE 3-2-67 22cw. SIGNATURE Charles Judge 22cx. DATE 3-2-67 22cy. SIGNATURE Charles Judge 22cz. DATE 3-2-67 22da. SIGNATURE Charles Judge 22db. DATE 3-2-67 22dc. SIGNATURE Charles Judge 22dd. DATE 3-2-67 22de. SIGNATURE Charles Judge 22df. DATE 3-2-67 22dg. SIGNATURE Charles Judge 22dh. DATE 3-2-67 22di. SIGNATURE Charles Judge 22dj. DATE 3-2-67 22dk. SIGNATURE Charles Judge 22dl. DATE 3-2-67 22dm. SIGNATURE Charles Judge 22dn. DATE 3-2-67 22do. SIGNATURE Charles Judge 22dp. DATE 3-2-67 22dq. SIGNATURE Charles Judge 22dr. DATE 3-2-67 22ds. SIGNATURE Charles Judge 22dt. DATE 3-2-67 22du. SIGNATURE Charles Judge 22dv. DATE 3-2-67 22dw. SIGNATURE Charles Judge 22dx. DATE 3-2-67 22dy. SIGNATURE Charles Judge 22dz. DATE 3-2-67 22ea. SIGNATURE Charles Judge 22eb. DATE 3-2-67 22ec. SIGNATURE Charles Judge 22ed. DATE 3-2-67 22ee. SIGNATURE Charles Judge 22ef. DATE 3-2-67 22eg. SIGNATURE Charles Judge 22eh. DATE 3-2-67 22ei. SIGNATURE Charles Judge 22ej. DATE 3-2-67 22ek. SIGNATURE Charles Judge 22el. DATE 3-2-67 22em. SIGNATURE Charles Judge 22en. DATE 3-2-67 22eo. SIGNATURE Charles Judge 22ep. DATE 3-2-67 22eq. SIGNATURE Charles Judge 22er. DATE 3-2-67 22es. SIGNATURE Charles Judge 22et. DATE 3-2-67 22eu. SIGNATURE Charles Judge 22ev. DATE 3-2-67 22ew. SIGNATURE Charles Judge 22ex. DATE 3-2-67 22ey. SIGNATURE Charles Judge 22ez. DATE 3-2-67 22fa. SIGNATURE Charles Judge 22fb. DATE 3-2-67 22fc. SIGNATURE Charles Judge 22fd. DATE 3-2-67 22fe. SIGNATURE Charles Judge 22ff. DATE 3-2-67 22fg. SIGNATURE Charles Judge 22fh. DATE 3-2-67 22fi. SIGNATURE Charles Judge 22fj. DATE 3-2-67 22fk. SIGNATURE Charles Judge 22fl. DATE 3-2-67 22fm. SIGNATURE Charles Judge 22fn. DATE 3-2-67 22fo. SIGNATURE Charles Judge 22fp. DATE 3-2-67 22fq. SIGNATURE Charles Judge 22fr. DATE 3-2-67 22fs. SIGNATURE Charles Judge 22ft. DATE 3-2-67 22fu. SIGNATURE Charles Judge 22fv. DATE 3-2-67 22fw. SIGNATURE Charles Judge 22fx. DATE 3-2-67 22fy. SIGNATURE Charles Judge 22fz. DATE 3-2-67 22ga. SIGNATURE Charles Judge 22gb. DATE 3-2-67 22gc. SIGNATURE Charles Judge 22gd. DATE 3-2-67 22ge. SIGNATURE Charles Judge 22gf. DATE 3-2-67 22gg. SIGNATURE Charles Judge 22gh. DATE 3-2-67 22gi. SIGNATURE Charles Judge 22gj. DATE 3-2-67 22gk. SIGNATURE Charles Judge 22gl. DATE 3-2-67 22gm. SIGNATURE Charles Judge 22gn. DATE 3-2-67 22go. SIGNATURE Charles Judge 22gp. DATE 3-2-67 22gq. SIGNATURE Charles Judge 22gr. DATE 3-2-67 22gs. SIGNATURE Charles Judge 22gt. DATE 3-2-67 22gu. SIGNATURE Charles Judge 22gv. DATE 3-2-67 22gw. SIGNATURE Charles Judge 22gx. DATE 3-2-67 22gy. SIGNATURE Charles Judge 22gz. DATE 3-2-67 22ha. SIGNATURE Charles Judge 22hb. DATE 3-2-67 22hc. SIGNATURE Charles Judge 22hd. DATE 3-2-67 22he. SIGNATURE Charles Judge 22hf. DATE 3-2-67 22hg. SIGNATURE Charles Judge 22hh. DATE 3-2-67 22hi. SIGNATURE Charles Judge 22hj. DATE 3-2-67 22hk. SIGNATURE Charles Judge 22hl. DATE 3-2-67 22hm. SIGNATURE Charles Judge 22hn. DATE 3-2-67 22ho. SIGNATURE Charles Judge 22hp. DATE 3-2-67 22hq. SIGNATURE Charles Judge 22hr. DATE 3-2-67 22hs. SIGNATURE Charles Judge 22ht. DATE 3-2-67 22hu. SIGNATURE Charles Judge 22hv. DATE 3-2-67 22hw. SIGNATURE Charles Judge 22hx. DATE 3-2-67 22hy. SIGNATURE Charles Judge 22hz. DATE 3-2-67 22ia. SIGNATURE Charles Judge 22ib. DATE 3-2-67 22ic. SIGNATURE Charles Judge 22id. DATE 3-2-67 22ie. SIGNATURE Charles Judge 22if. DATE 3-2-67 22ig. SIGNATURE Charles Judge 22ih. DATE 3-2-67 22ii. SIGNATURE Charles Judge 22ij. DATE 3-2-67 22ik. SIGNATURE Charles Judge 22il. DATE 3-2-67 22im. SIGNATURE Charles Judge 22in. DATE 3-2-67 22io. SIGNATURE Charles Judge 22ip. DATE 3-2-67 22iq. SIGNATURE Charles Judge 22ir. DATE 3-2-67 22is. SIGNATURE Charles Judge 22it. DATE 3-2-67 22iu. SIGNATURE Charles Judge 22iv. DATE 3-2-67 22iw. SIGNATURE Charles Judge 22ix. DATE 3-2-67 22iy. SIGNATURE Charles Judge 22iz. DATE 3-2-67 22ja. SIGNATURE Charles Judge 22jb. DATE 3-2-67 22jc. SIGNATURE Charles Judge 22jd. DATE 3-2-67 22je. SIGNATURE Charles Judge 22jf. DATE 3-2-67 22jg. SIGNATURE Charles Judge 22jh. DATE 3-2-67 22ji. SIGNATURE Charles Judge 22jj. DATE 3-2-67 22jk. SIGNATURE Charles Judge 22jl. DATE 3-2-67 22jm. SIGNATURE Charles Judge 22jn. DATE 3-2-67 22jo. SIGNATURE Charles Judge 22jp. DATE 3-2-67 22jq. SIGNATURE Charles Judge 22jr. DATE 3-2-67 22js. SIGNATURE Charles Judge 22jt. DATE 3-2-67 22ju. SIGNATURE Charles Judge 22jv. DATE 3-2-67 22jw. SIGNATURE Charles Judge 22jx. DATE 3-2-67 22jy. SIGNATURE Charles Judge 22jz. DATE 3-2-67 22ka. SIGNATURE Charles Judge 22kb. DATE 3-2-67 22kc. SIGNATURE Charles Judge 22kd. DATE 3-2-67 22ke. SIGNATURE Charles Judge 22kf. DATE 3-2-67 22kg. SIGNATURE Charles Judge 22kh. DATE 3-2-67 22ki. SIGNATURE Charles Judge 22kj. DATE 3-2-67 22kk. SIGNATURE Charles Judge 22kl. DATE 3-2-67 22km. SIGNATURE Charles Judge 22kn. DATE 3-2-67 22ko. SIGNATURE Charles Judge 22kp. DATE 3-2-67 22kq. SIGNATURE Charles Judge 22kr. DATE 3-2-67 22ks. SIGNATURE Charles Judge 22kt. DATE 3-2-67 22ku. SIGNATURE Charles Judge 22kv. DATE 3-2-67 22kw. SIGNATURE Charles Judge 22kx. DATE 3-2-67 22ky. SIGNATURE Charles Judge 22kz. DATE 3-2-67 22la. SIGNATURE Charles Judge 22lb. DATE 3-2-67 22lc. SIGNATURE Charles Judge 22ld. DATE 3-2-67 22le. SIGNATURE Charles Judge 22lf. DATE 3-2-67 22lg. SIGNATURE Charles Judge 22lh. DATE 3-2-67 22li. SIGNATURE Charles Judge 22lj. DATE 3-2-67 22lk. SIGNATURE Charles Judge 22ll. DATE 3-2-67 22lm. SIGNATURE Charles Judge 22ln. DATE 3-2-67 22lo. SIGNATURE Charles Judge 22lp. DATE 3-2-67 22lq. SIGNATURE Charles Judge 22lr. DATE 3-2-67 22ls. SIGNATURE Charles Judge 22lt. DATE 3-2-67 22lu. SIGNATURE Charles Judge 22lv. DATE 3-2-67 22lw. SIGNATURE Charles Judge 22lx. DATE 3-2-67 22ly. SIGNATURE Charles Judge 22lz. DATE 3-2-67 22ma. SIGNATURE Charles Judge 22mb. DATE 3-2-67 22mc. SIGNATURE Charles Judge 22md. DATE 3-2-67 22me. SIGNATURE Charles Judge 22mf. DATE 3-2-67 22mg. SIGNATURE Charles Judge 22mh. DATE 3-2-67 22mi. SIGNATURE Charles Judge 22mj. DATE 3-2-67 22mk. SIGNATURE Charles Judge 22ml. DATE 3-2-67 22mn. SIGNATURE Charles Judge 22mo. DATE 3-2-67 22mp. SIGNATURE Charles Judge 22mq. SIGNATURE Charles Judge 22mr. DATE 3-2-67 22ms. SIGNATURE Charles Judge 22mt. DATE 3-2-67 22mu. SIGNATURE Charles Judge 22mv. DATE 3-2-67 22mw. SIGNATURE Charles Judge 22mx. DATE 3-2-67 22my. SIGNATURE Charles Judge 22mz. DATE 3-2-67 22na. SIGNATURE Charles Judge 22nb. DATE 3-2-67 22nc. SIGNATURE Charles Judge 22nd. DATE 3-2-67 22ne. SIGNATURE Charles Judge 22nf. DATE 3-2-67 22ng. SIGNATURE Charles Judge 22nh. DATE 3-2-67 22ni. SIGNATURE Charles Judge 22nj. DATE 3-2-67 22nk. SIGNATURE Charles Judge 22nl. DATE 3-2-67 22nm. SIGNATURE Charles Judge 22no. DATE 3-2-67 22np. SIGNATURE Charles Judge 22nq. SIGNATURE Charles Judge 22nr. DATE 3-2-67 22ns. SIGNATURE Charles Judge 22nt. DATE 3-2-67 22nu. SIGNATURE Charles Judge 22nv. DATE 3-2-67 22nw. SIGNATURE Charles Judge 22nx. DATE 3-2-67 22ny. SIGNATURE Charles Judge 22nz. DATE 3-2-67 22oa. SIGNATURE Charles Judge 22ob. DATE 3-2-67 22oc. SIGNATURE Charles Judge 22od. DATE 3-2-67 22oe. SIGNATURE Charles Judge 22of. DATE 3-2-67 22og. SIGNATURE Charles Judge 22oh. DATE 3-2-67 22oi. SIGNATURE Charles Judge 22oj. DATE 3-2-67 22ok. SIGNATURE Charles Judge 22ol. DATE 3-2-67 22om. SIGNATURE Charles Judge 22on. DATE 3-2-67 22op. SIGNATURE Charles Judge 22oq. SIGNATURE Charles Judge 22or. DATE 3-2-67 22os. SIGNATURE Charles Judge 22ot. DATE 3-2-67 22ou. SIGNATURE Charles Judge 22ov. DATE 3-2-67 22ow. SIGNATURE Charles Judge 22ox. DATE 3-2-67 22oy. SIGNATURE Charles Judge 22oz. DATE 3-2-67 22pa. SIGNATURE Charles Judge 22pb. DATE 3-2-67 22pc. SIGNATURE Charles Judge 22pd. DATE 3-2-67 22pe. SIGNATURE Charles Judge 22pf. DATE 3-2-67 22pg. SIGNATURE Charles Judge 22ph. DATE 3-2-67 22pi. SIGNATURE Charles Judge 22pj. DATE 3-2-67 22pk. SIGNATURE Charles Judge 22pl. DATE 3-2-67 22pm. SIGNATURE Charles Judge 22pn. DATE 3-2-67 22po. SIGNATURE Charles Judge 22pq. SIGNATURE Charles Judge 22pr. DATE 3-2-67 22ps. SIGNATURE Charles Judge 22pt. DATE 3-2-67 22pu. SIGNATURE Charles Judge 22pv. DATE 3-2-67 22pw. SIGNATURE Charles Judge 22px. DATE 3-2-67 22py. SIGNATURE Charles Judge 22pz. DATE 3-2-67 22qa. SIGNATURE Charles Judge 22qb. DATE 3-2-67 22qc. SIGNATURE Charles Judge 22qd. DATE 3-2-67 22qe. SIGNATURE Charles Judge 22qf. DATE 3-2-67 22qg. SIGNATURE Charles Judge 22qh. DATE 3-2-67 22qi. SIGNATURE Charles Judge 22qj. DATE 3-2-67 22qk. SIGNATURE Charles Judge 22ql. DATE 3-2-67 22qm. SIGNATURE Charles Judge 22qn. DATE 3-2-67 22qo. SIGNATURE Charles Judge 22qp. DATE 3-2-67 22qq. SIGNATURE Charles Judge 22qr. DATE 3-2-67 22qs. SIGNATURE Charles Judge 22qt. DATE 3-2-67 22qu. SIGNATURE Charles Judge 22qv. DATE 3-2-67 22qw. SIGNATURE Charles Judge 22qx. DATE 3-2-67 22qy. SIGNATURE Charles Judge 22qz. DATE 3-2-67 22ra. SIGNATURE Charles Judge 22rb. DATE 3-2-67 22rc. SIGNATURE Charles Judge 22rd. DATE 3-2-67 22re. SIGNATURE Charles Judge 22rf. DATE 3-2-67 22rg. SIGNATURE Charles Judge 22rh. DATE 3-2-67 22ri. SIGNATURE Charles Judge 22rj. DATE 3-2-67 22rk. SIGNATURE Charles Judge 22rl. DATE 3-2-67 22rm. SIGNATURE Charles Judge 22rn. DATE 3-2-67 22ro. SIGNATURE Charles Judge 22rp. DATE 3-2-67 22rq. SIGNATURE Charles Judge 22rr. DATE 3-2-67 22rs. SIGNATURE Charles Judge 22rt. DATE 3-2-67 22ru. SIGNATURE Charles Judge 22rv. DATE 3-2-67 22rw. SIGNATURE Charles Judge 22rx. DATE 3-2-67 22ry. SIGNATURE Charles Judge 22rz. DATE 3-2-67 22sa. SIGNATURE Charles Judge 22sb. DATE 3-2-67 22sc. SIGNATURE Charles Judge 22sd. DATE 3-2-67 22se. SIGNATURE Charles Judge 22sf. DATE 3-2-67 22sg. SIGNATURE Charles Judge 22sh. DATE 3-2-67 22si. SIGNATURE Charles Judge 22sj. DATE 3-2-67 22sk. SIGNATURE Charles Judge 22sl. DATE 3-2-67 22sm. SIGNATURE Charles Judge 22sn. DATE 3-2-67 22so. SIGNATURE Charles Judge 22sp. DATE 3-2-67 22sq. SIGNATURE Charles Judge 22sr. DATE 3-2-67 22ss. SIGNATURE Charles Judge 22st. DATE 3-2-67 22su. SIGNATURE Charles Judge 22sv. DATE 3-2-67 22sw. SIGNATURE Charles Judge 22sx. DATE 3-2-67 22sy. SIGNATURE Charles Judge 22sz. DATE 3-2-67 22ta. SIGNATURE Charles Judge 22tb. DATE 3-2-67 22tc. SIGNATURE Charles Judge 22td. DATE 3-2-67 22te. SIGNATURE Charles Judge 22tf. DATE 3-2-67 22tg. SIGNATURE Charles Judge 22th. DATE 3-2-67 22ti. SIGNATURE Charles Judge 22tj. DATE 3-2-67 22tk. SIGNATURE Charles Judge 22tl. DATE 3-2-67 22tm. SIGNATURE Charles Judge 22tn. DATE 3-2-67 22to. SIGNATURE Charles Judge 22tp. DATE 3-2-67 22tq. SIGNATURE Charles Judge 22tr. DATE 3-2-67 22ts. SIGNATURE Charles Judge 22tt. DATE 3-2-67 22tu. SIGNATURE Charles Judge 22tv. DATE 3-2-67 22tw. SIGNATURE Charles Judge 22tx. DATE 3-2-67 22ty. SIGNATURE Charles Judge 22tz. DATE 3-2-67 22ua. SIGNATURE Charles Judge 22ub. DATE 3-2-67 22uc. SIGNATURE Charles Judge 22ud. DATE 3-2-67 22ue. SIGNATURE Charles Judge 22uf. DATE 3-2-67 22ug. SIGNATURE Charles Judge 22uh. DATE 3-2-67 22ui. SIGNATURE Charles Judge 22uj. DATE 3-2-67 22uk. SIGNATURE Charles Judge 22ul. DATE 3-2-67 22um. SIGNATURE Charles Judge 22un. DATE 3-2-67 22uo. SIGNATURE Charles Judge 22up. DATE 											



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of the body from any event within 72 hours after death.

VR A15ME
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01901

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01896

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY in 1b <u>#14</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ST. JOSEPH HOSPITAL</u>		d. STREET ADDRESS <u>3604 WHITE AVE</u>	
3 NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Guy</u> Last <u>MORGRET</u>		4 DATE OF DEATH Month <u>FEB</u> Day <u>3</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>2-24-13</u>
10a USUAL OCC. PAT ON (Give kind of work done during most of working life even if retired) <u>Salesman</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>	11 BIRTHPLACE (State or foreign country) <u>Penna.</u>
13. FATHER'S NAME <u>Clarence Morgret</u>		14 MOTHER'S MAIDEN NAME <u>Mamie ?</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>Yes WW2</u>		16 SOC. A. SECURITY NO. <u>172-18-0241</u>	
17. INFORMANT <u>Mr. James G. Morgret Jr. Johnstown, Pa.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.		22. DATE SIGNED <u>2-3-67</u>	
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>		DEPUTY MEDICAL EXAMINER <u>BALTIMORE</u> Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>2/8/67.</u>	23c NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR <u>Lecnard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

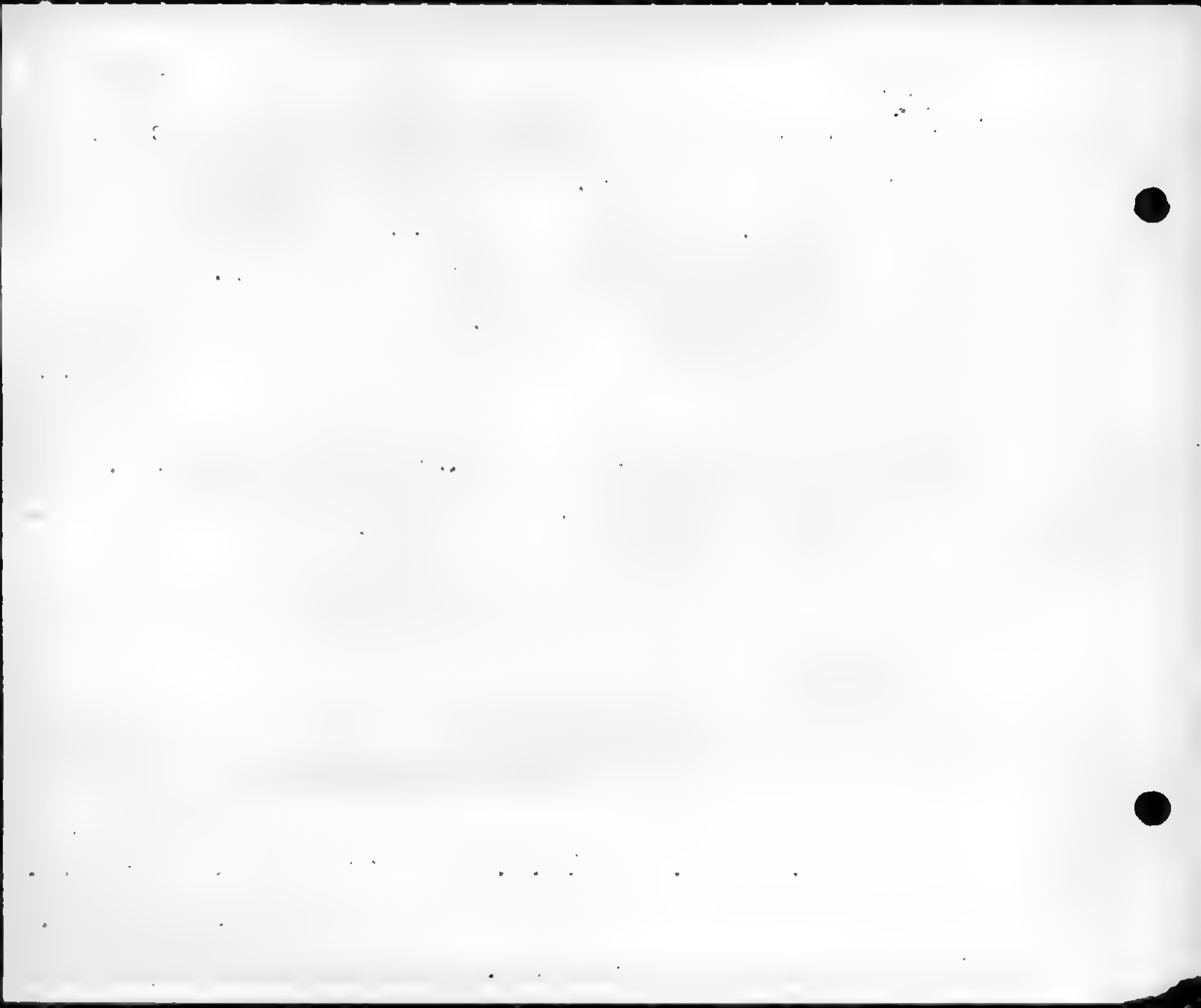
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01902

CERTIFICATE OF DEATH

01898

1. PLACE OF DEATH a. COUNTY Balto. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b 5 Mon.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 119 Croftley Rd.				d. STREET ADDRESS R.D. 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Andrew (Netraj) Netro				4. DATE OF DEATH Month Feb. Day 9, Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1883	9. AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Netro				14. MOTHER'S MAIDEN NAME Judita Hamlik			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-34-6145		17. INFORMANT Address Mrs. Julia Netro Hampstead, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO coronary insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? (c) ?						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Jan 25, 1967 to Feb 9, 1967 , that (1) (we) last saw the deceased alive on Jan 25, 1967 , and that death occurred at 8:15 A.M. from causes and on the date stated above.							
22a. SIGNATURE George T. Gilmore M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb 10, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. George T. Gilmore, M. D.				22d. ADDRESS 1717 York Road, Lutherville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/67		23c. NAME OF CEMETERY OR CREMATORY Hampstead		23d. LOCATION (City or Town) (County) (State) Hampstead, Carroll Md.	
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.				25a. REC'D BY REGISTRAR DATE FEB 14 1967		25b. REGISTRAR'S SIGNATURE James J. [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

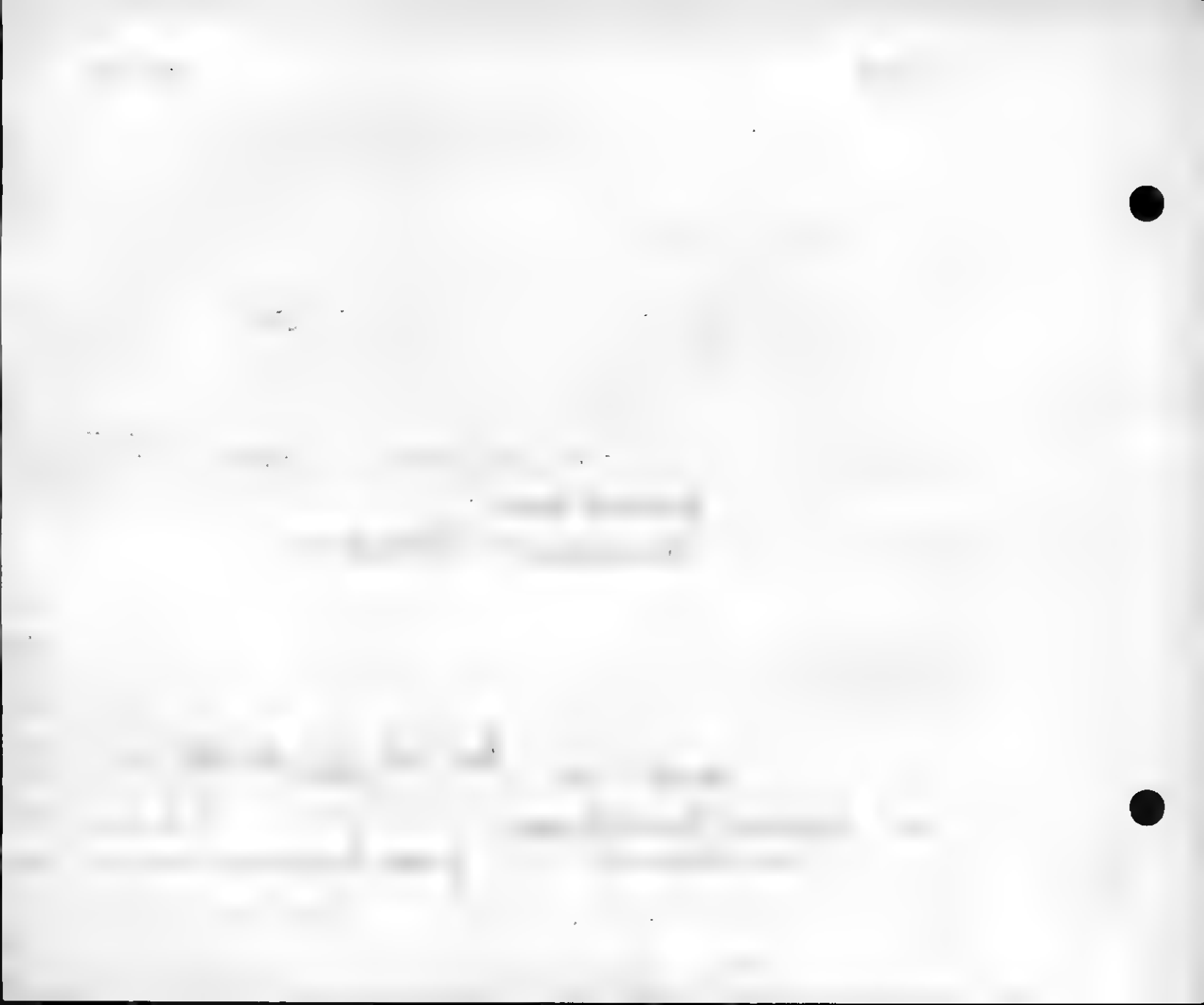
01903

01899

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c LENGTH OF STAY IN TB <u>10 days</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				d. STREET ADDRESS <u>7016 Brewster Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Anthony Nichols</u>				4. DATE OF DEATH Month Day Year <u>2 8 1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1883</u>		9. AGE (In years last birthday) <u>84</u> yrs	10. UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cethus, Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>One Honey Nicholas</u>				14. MOTHER'S MAIDEN NAME <u>Firzees</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ce) <u>NO</u>		16 SOCIAL SECURITY NO <u>172-03-4400</u>		17 INFORMANT <u>MRS. EDW. A. O'BARA</u>		Address <u>SEE # 2 ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Stomach</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 29th</u> 19 <u>67</u> , to <u>Feb. 8th</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 8th</u> 19 <u>67</u> , and that death occurred at <u>9:40pm</u> , from causes and on the date stated above.							
22a SIGNATURE <u>Dr. Isabelle Mae Greco</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED <u>2-8-67</u>	
22c PHYSICIAN'S NAME (Type) <u>I. MAE GREGORY</u>				22d ADDRESS <u>Greater Baltimore Medical Center</u>			
23a BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>2/13/1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>GRAND VIEW</u>		23d LOCATION (City or Town) (County) (State) <u>JOHNS TOWN, PENN.</u>	
24 FUNERAL DIRECTOR <u>W. Brooks Bradley, Dundalk, Md</u>				25a REC'D BY REGISTRAR DATE <u>FEB 10 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

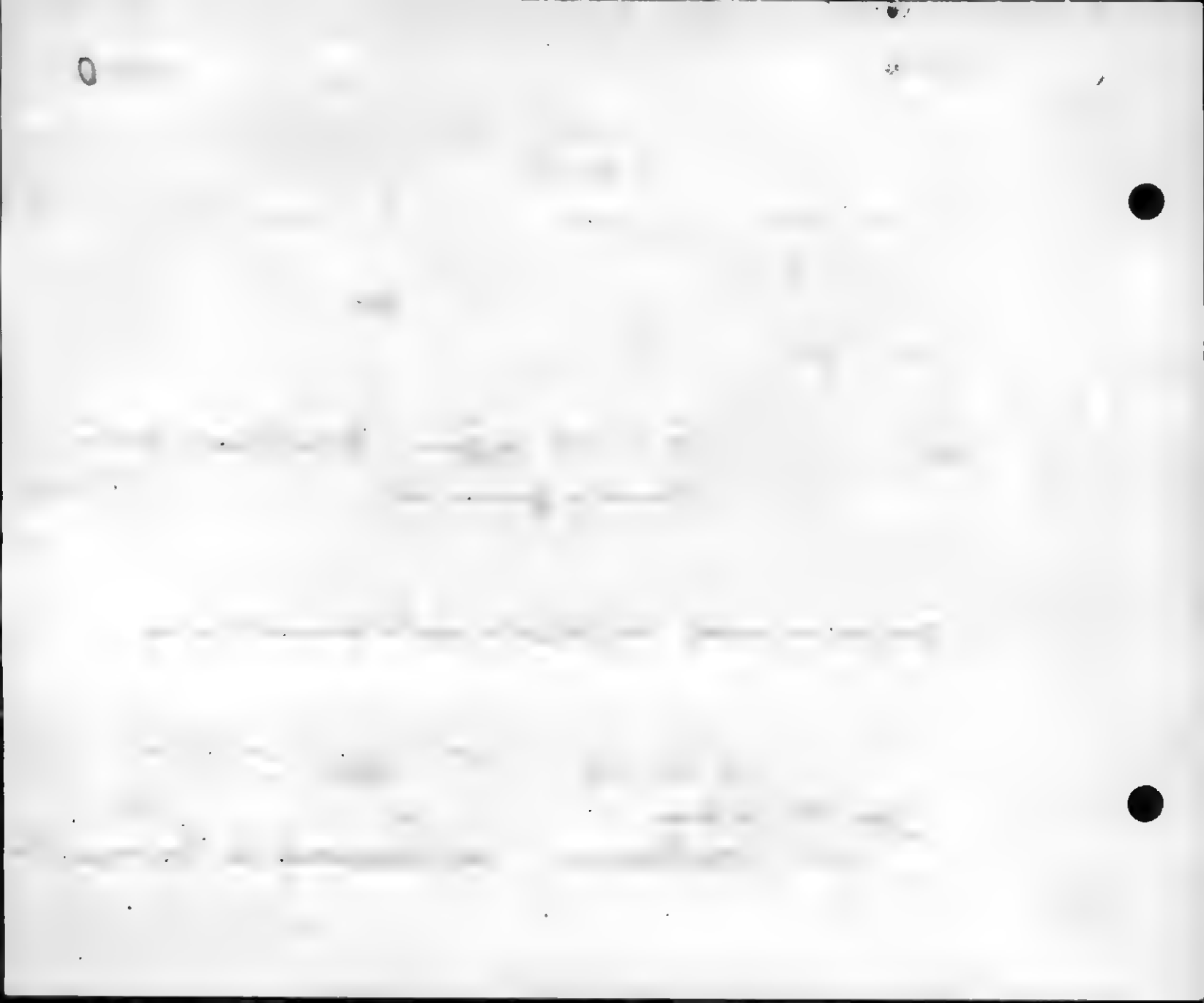


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01904						01900					
1. PLACE OF DEATH a. COUNTY <u>Balto.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Balto</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>4 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dulaney Towson Nursing Home</u>						d. STREET ADDRESS <u>8034 Kearnagh Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u></u> Last <u>O'Hare</u>						4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 20, 1888</u>		9. AGE (In years last birthday) <u>78 yrs.</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>CARL Miller</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>102 07 3768</u>		17. INFORMANT <u>Nursing Home Record Towson</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular insufficiency due to arteriosclerosis</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10-17-1966</u> to <u>2-16, 1967</u> , that (I) (we) last saw the deceased alive on <u>2-15-1967</u> , and that death occurred at <u>2:00</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>James J. McPhillips</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-16-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>James J. McPhillips</u>						22d. ADDRESS <u>4617 MANORDENE RD BALTIMORE MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Feb 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Long Island, New York</u>			
24. FUNERAL DIRECTOR <u>Wm. Cook Brooks Towson</u>						ADDRESS <u>1030 York Rd Towson, Md</u>		25a. REC'D BY REGISTRAR <u>1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>	

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

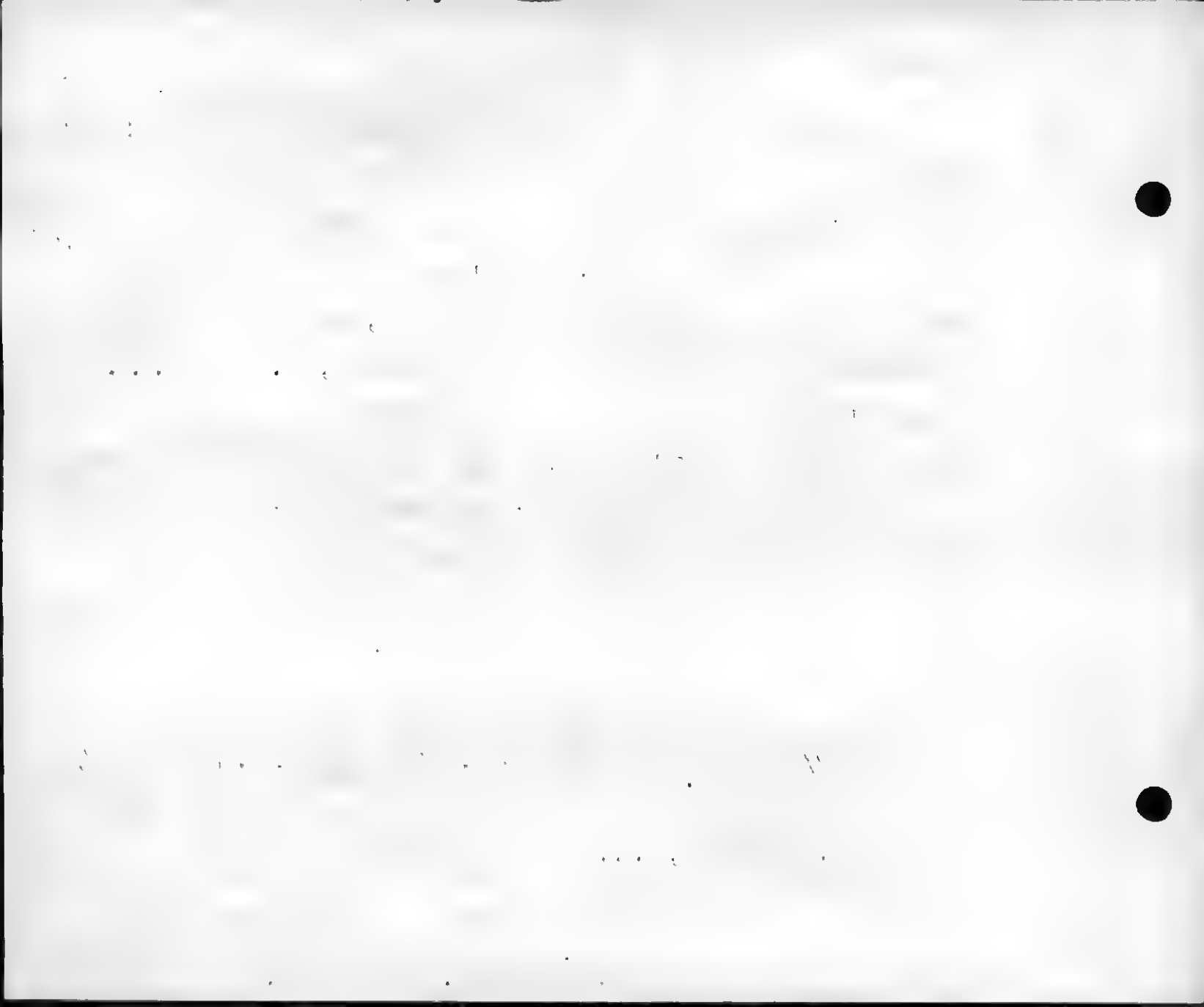
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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01905

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c LENGTH OF STAY IN 1b 11 DAYS	c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d STREET ADDRESS 8132 MIDHAVEN ROAD		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last JACK D. O'NEAL			4 DATE OF DEATH Month Day Year FEBRUARY 7 1967				
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH SEPTEMBER 19, 1898		9 AGE (in years last birthday) 68 yrs	IF UNDER 1 YEAR Months Days Hours Mins. 0 0 0 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10b. KIND OF BUSINESS OR INDUSTRY MOTOR LODGE		11. BIRTHPLACE (County & State or foreign country) PORT REPUBLIC, VA.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES O'NEAL			14. MOTHER'S MAIDEN NAME EMMA VANLEAR				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 204-01 87 50		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, UNDETERMINED ORGANISM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) LYMPHOMA						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL ARTERIOSCLEROSIS; CHRONIC PYELONEPHRITIS, STREPTOCOCCUS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20d. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. (City or town) (County) (State)			
21. I certify that IV (this hospital) attended the deceased from JAN. 27 , 19 67 , to FEB. 7 , 19 67 , that IV (we) last saw the deceased alive on FEB. 7 , 19 67 , and that death occurred at 925 PM , from causes and on the date stated above.							
22a. SIGNATURE Neilson Neilson M.D.		22b. DATE SIGNED 2/8/67		22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.			
22d. ADDRESS VAH FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/10/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Joseph N. Zannino		25a. REC'D BY REGISTRAR Joseph N. Zannino		25b. REGISTRAR'S SIGNATURE Charles Judge			



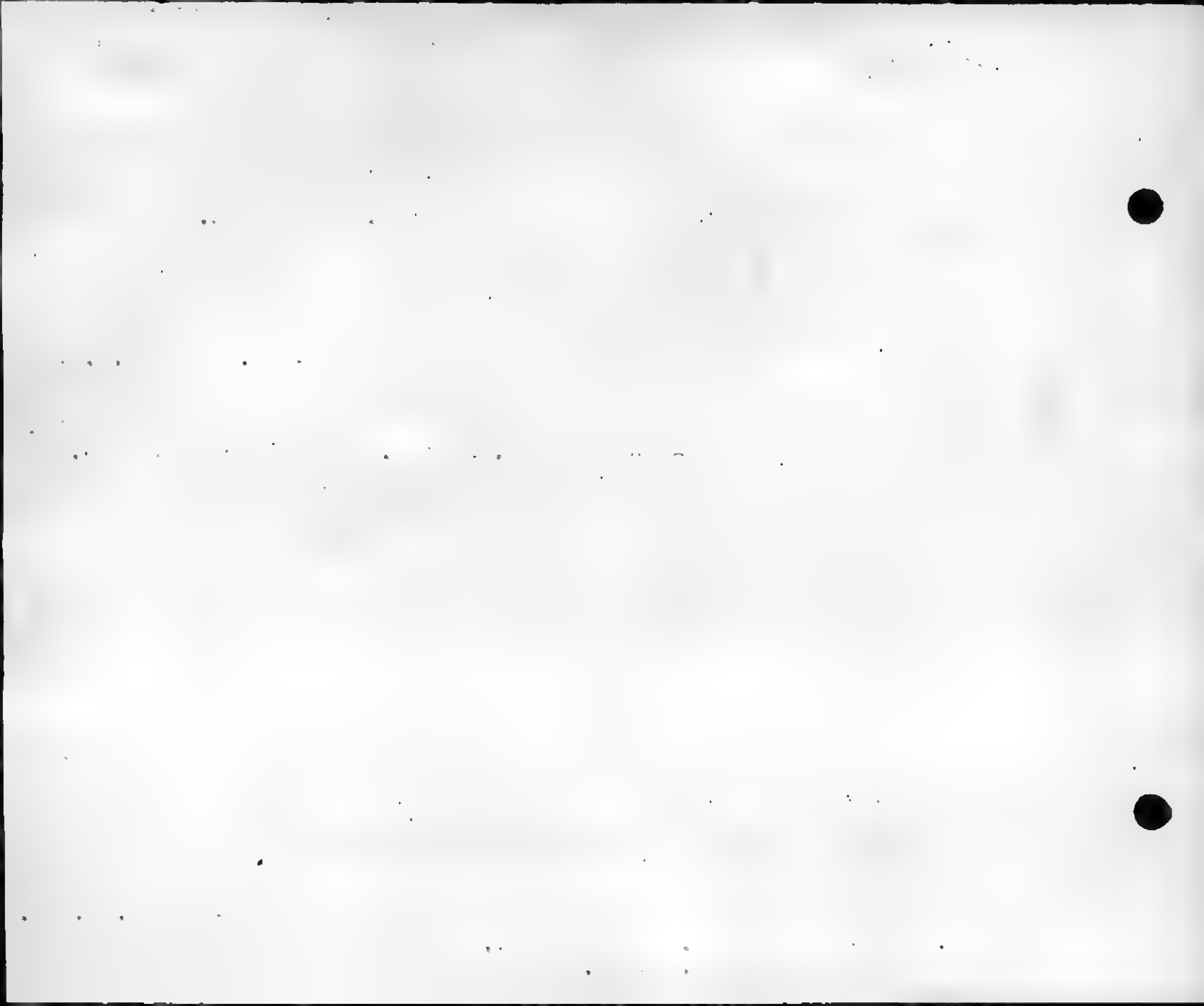
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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01906					01902						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Baltimore					a. STATE Maryland						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore						
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS 3700 N. Charles St.						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dulaney Towson Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First Jesse			Middle Loeffler			Last Palmer		
4. DATE OF DEATH			Month February			Day 7			Year 1967		
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/29/1877		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Loeffler						14. MOTHER'S MAIDEN NAME Rachel Owens					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216-09-1437		17. INFORMANT Mrs. Anne L. Sinclair-Smith, Tenn.				Address Nashville,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1958 to Feb 7 , 19 67 , that (I) (we) last saw the deceased alive on Feb 7 , 19 67 , and that death occurred at 8:00 M, from the causes and on the date stated above.											
22a. SIGNATURE William G. Helfrich						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich						22d. ADDRESS 5006 Roland Ave.		22b. DATE SIGNED 2-8-67			
23a. BURIAL, CREMATION, REMEMORIAL (Specify) Burial			23b. DATE THEREOF 2/9/1967		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge			23d. LOCATION (City, town or county) (State) Pikesville, Balto. Co. Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.						25a. REC'D BY REGISTRAR DATE FEB 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judy			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01907

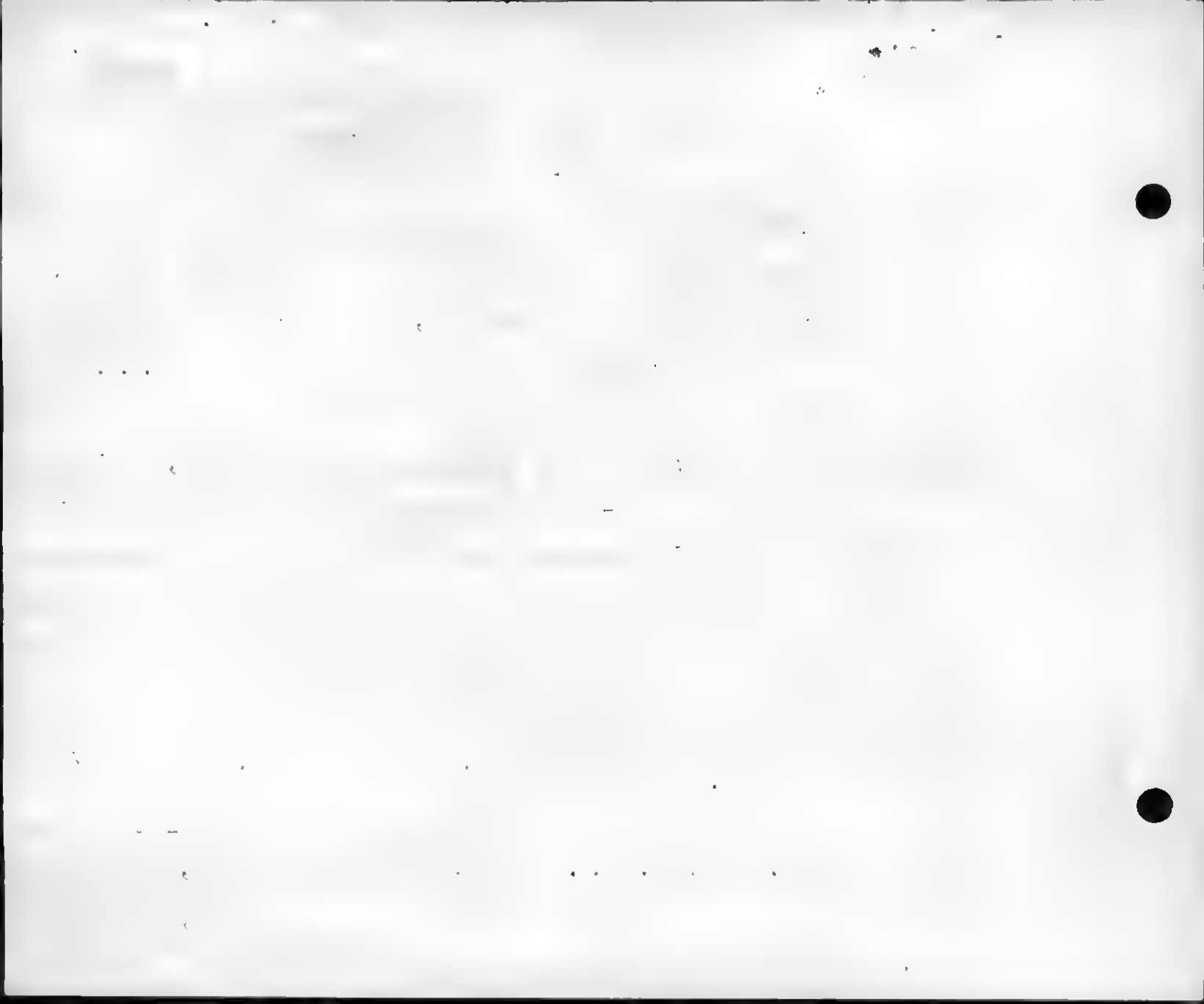
CERTIFICATE OF DEATH

01903

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		2 USUAL RESIDENCE (Where deceased lived, if institution) MARYLAND a. STATE MARYLAND b. COUNTY	
c. LENGTH OF STAY IN 1b 59 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 3038 BRIGHTON STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First LOUIS Middle DAVIDSON Last PARKER		4. DATE OF DEATH Month FEBRUARY Day 24 Year 19 67	
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MARCH 22, 1906
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DONALD PARKER		14. MOTHER'S MARDEN NAME ALETHEA DAVIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWII		16. SOCIAL SECURITY NO. 718 03 34 85	
17. INFORMANT CLINICAL RECORDS		Address FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF LARYNX DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DEC. 27 , 19 66 , to FEB. 24 , 19 67 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on FEB. 24 , 19 67 , and that death occurred at 500PM , from causes and on the date stated above			
22a. SIGNATURE Jose A. Raquel Jr.		22b. DATE SIGNED 2-24-67	
22c. PHYSICIAN'S NAME (Type) JOSE A. RAQUEL JR., M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/28/67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR NUTTER FUNERAL HOME		25a. REC'D BY REGISTRAR FEB 27 1967	
3035 W. NORTH AVENUE, BALTIMORE, MARYLAND		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

01908

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01904

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY in 1b 3 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital			d. STREET ADDRESS 341 North Jonathan St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES DEWITT PARSON			4. DATE OF DEATH Month Day Year 2 16 19 67		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-56	9. AGE (In years last birthday) 10 yrs	IF UNDER 1 YEAR Months Days Hours Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Harford County, Md.	
13. FATHER'S NAME Tom Parson			14. MOTHER'S MAIDEN NAME Yvonne Elizabeth Medley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO none		17. INFORMANT Address Rosewood Records, Owings Mills, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 471X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 1
PART II. CONTRIBUTING CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Post hepatic liver cirrhosis					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Rudiger Breiteneker, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 2/17/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 21 1967	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Md.		
24. FUNERAL DIRECTOR John R. Watson Jr. Hagerstown Md.		25d. REC'D BY REGISTRAR DATE FEB 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01905

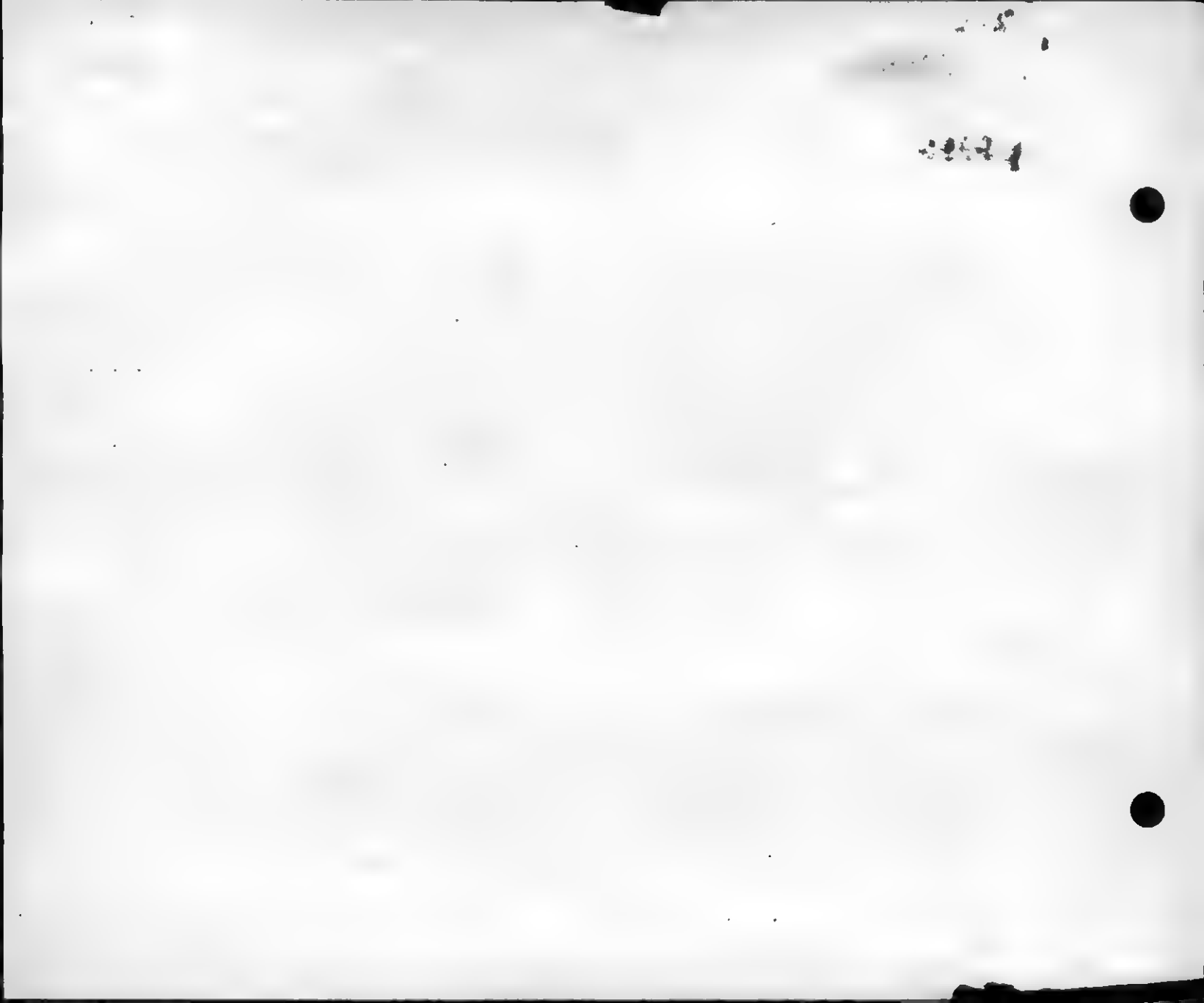
CERTIFICATE OF DEATH

01905

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson (Ruxton Towers)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center				d. STREET ADDRESS 8415 Bellona Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARVEY M PATTERSON				4. DATE OF DEATH Month FEB. Day 15 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1914	9. AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Reathy Mack Patterson				14. MOTHER'S MAIDEN NAME Lula Mae Bryant			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 2/		17. INFORMANT 604 Orpington Rd. Wayne D. Albrecht, Baltimore, Maryland 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (b) DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-16 , 1967, to 2-15 , 1967, that (I) (we) last saw the deceased alive on 2-15 , 1967, and that death occurred at 11:30 PM , from causes and on the date stated above.							
22a. SIGNATURE Juan L. Roque				22b. DATE SIGNED 2-15-67		22c. PHYSICIAN'S NAME (Type) JUAN L. ROQUE	
22d. ADDRESS GBMC. Towson, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Baltimore, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204				25a. REC'D BY REGISTRAR FEB 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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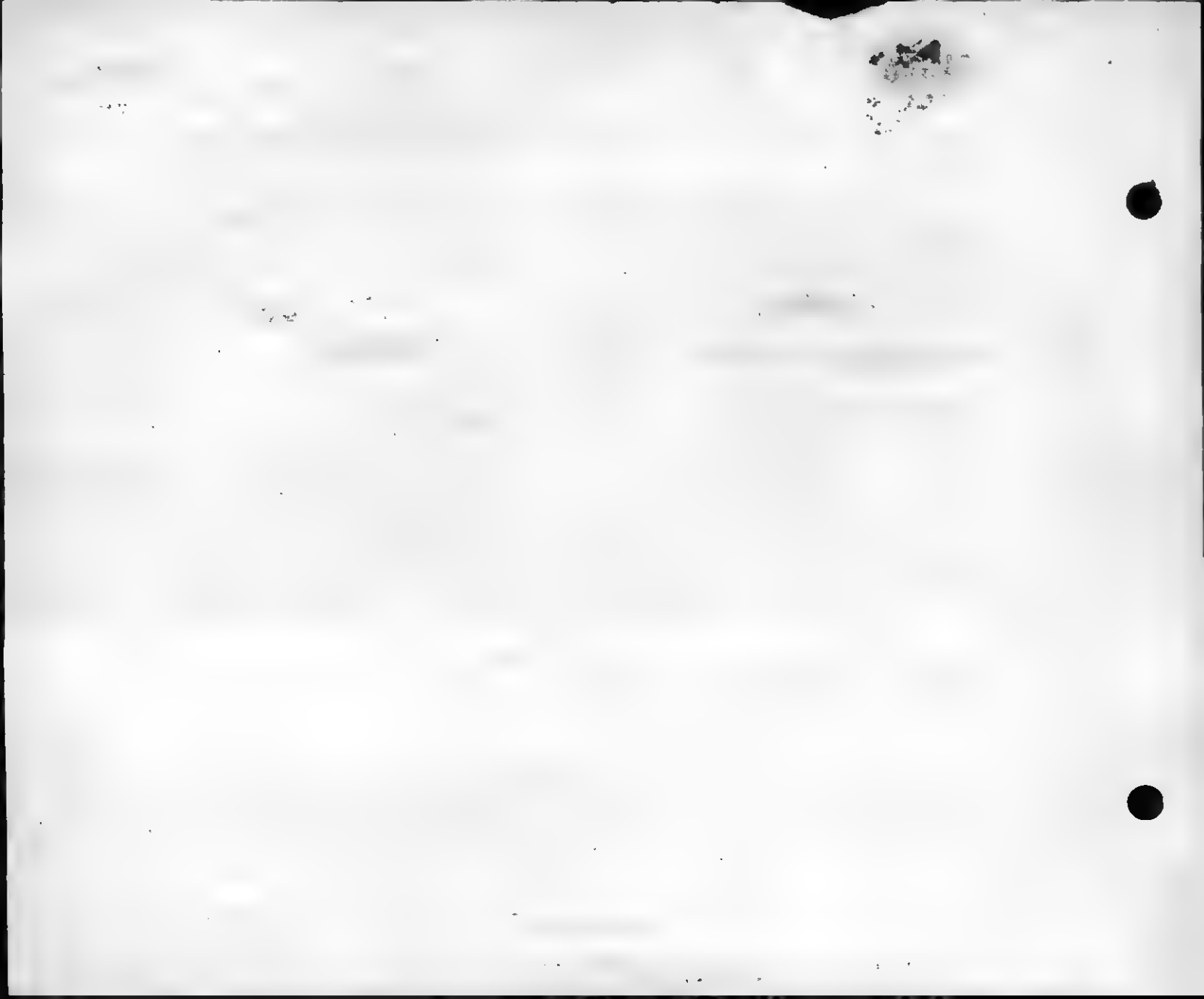


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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
01910												
01906												
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>				c. LENGTH OF STAY IN ID <u>20 da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foxleigh Nursing Home.</u>						d. STREET ADDRESS <u>3834 Ball Mall Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>N.</u> Last <u>PEARLSTEIN</u>						4. DATE OF DEATH Month <u>Feb.</u> Day <u>14</u> Year <u>1967</u>						
5. SEX <u>White</u>		6. COLOR OR RACE <u>M</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/23/1890</u> <u>76</u> yrs.		9. AGE (In years last birthday) Months <u>76</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. FUND 1 YEAR <input type="checkbox"/> FUND 24 HRS. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Clothing</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Clothing</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Salesman</u> <u>Moishe Pearlstein</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>110-05-8046</u>		17. INFORMANT <u>Harold Pearlstein</u>				Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanoma carcinoma disseminated</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>65</u> , to <u>7/14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/13</u> , 19 <u>67</u> , and that death occurred at <u>4:15</u> A.M., from the causes and on the date stated above.												
22a. SIGNATURE <u>Milton B. Kirsh</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/14/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Milton B. Kirsh, M.D.</u>						22d. ADDRESS <u>4000 W. Northern Parkway - 21215</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Anshe Emunah-Aitz Chaim</u>				23d. LOCATION (City, town or county) _____ (State) _____ <u>Baltimore, Maryland</u>				
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc.,</u>						25a. REC'D BY REGISTRAR <u>FEB 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01813

01907

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institut an Residence before admssion) a. STATE <u>Maryland</u> b. COUNTY <u>---</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Haven Nursing Home</u>				d. STREET ADDRESS <u>1023 South Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GIUSEPPI A. DEL SO</u>				4. DATE OF DEATH Month Day Year <u>February 3, 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/1/1906</u>	9. AGE (In years last birthday) <u>60</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Macaroni</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u> <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>Guy Peluso</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Fat. Peluso 307 S. Ann Street (Son)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART DISEASE</u> DUE TO <u>4.1.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATHEROSCLEROTIC CHANGES - CORONARY</u> DUE TO (c) <u>DISEASES</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>66</u> , to <u>2/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/3</u> , 19 <u>67</u> , and that death occurred at <u>6:12 AM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>John H. Johnson M.D.</u>				22b. DATE SIGNED <u>2/6/67</u>		22c. PHYSICIAN'S NAME (Type) <u>John H. Johnson M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>John H. Johnson</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1944

1944



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01912

01908

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8172 Kavanagh Road (Sidewalk)		e. STREET ADDRESS 8134 Kavanagh Road	
3 NAME OF DECEASED (Type or print) First MARCUS Middle Sarafin Last PENA		4 DATE OF DEATH Month February Day 16 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 22-1922
9 AGE (In years last birthday) 44 yrs		10 IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if not red) Jockey		10b KIND OF BUSINESS OR INDUSTRY Race Tracks	
11 BIRTHPLACE (State or foreign country) Havana, Cuba		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Sarafin Pena		14 MOTHER'S MAIDEN NAME Angela Zaballa	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOC. A. SECURITY NO. 508-20-4818	
17 INFORMANT Wife, Eileen, Pena, #2, a, b, c, d, .		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			INTERVAL BETWEEN ONSET AND DEATH
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breiteneker, MD EXAMINER'S NAME (Type)		22. DATE SIGNED 2/17/67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Feb-22-1967	23c NAME OF CEMETERY OR CREMATORY Woodlawn	23d LOCATION (City or town) (County) (State) Miami, Dade County, Florida
24. FUNERAL DIRECTOR JOHN J. DUDA, Dundalk, Maryland 21222		25a REC'D BY REGISTRAR FEB 20 1967	25b REGISTRAR'S SIGNATURE Charles J. ...

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TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

01913

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01909

1 PLACE OF DEATH a COUNTY BALTIMORE b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY BALTIMORE c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 427 Langley Road		e STREET ADDRESS 427 Langley Road, Edgewater Apt.	
3 NAME OF DECEASED (Type or print) First Chalmer Middle Dean Last PHIPPS		4 DATE OF DEATH Month February Day 12 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 4, 1917
9 AGE (in years last birthday) 49		10 IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Carpenter		10b KIND OF BUSINESS OR INDUSTRY North Carolina	
11 BIRTHPLACE (State or large county) North Carolina		12 CITIZEN OF WHAT COUNTRY? United States	
13 FATHER'S NAME Charlie W. Phipps		14 MOTHER'S MAIDEN NAME Margaret Eoff	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16 SOCIAL SECURITY NO 244-14-3448	
17 INFORMANT Howard Phipps		Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 Lobar pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Fatty metamorphosis of liver DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		22. DATE SIGNED February 20, 1967	
23a BURIAL, CREMATION, REMOVAL (Specify) Removal	23b DATE THEREOF 2/22/67	23c NAME OF CEMETERY OR CREMATORY Pleasant Valley	23d LOCATION (City or town) (County) (State) Ashe Co. N.C.
24 FUNERAL DIRECTOR Badger Funeral Home. N.C.		25a REC'D BY REGISTRAR DATE FEB 23 1967	25b REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

1944

1944

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

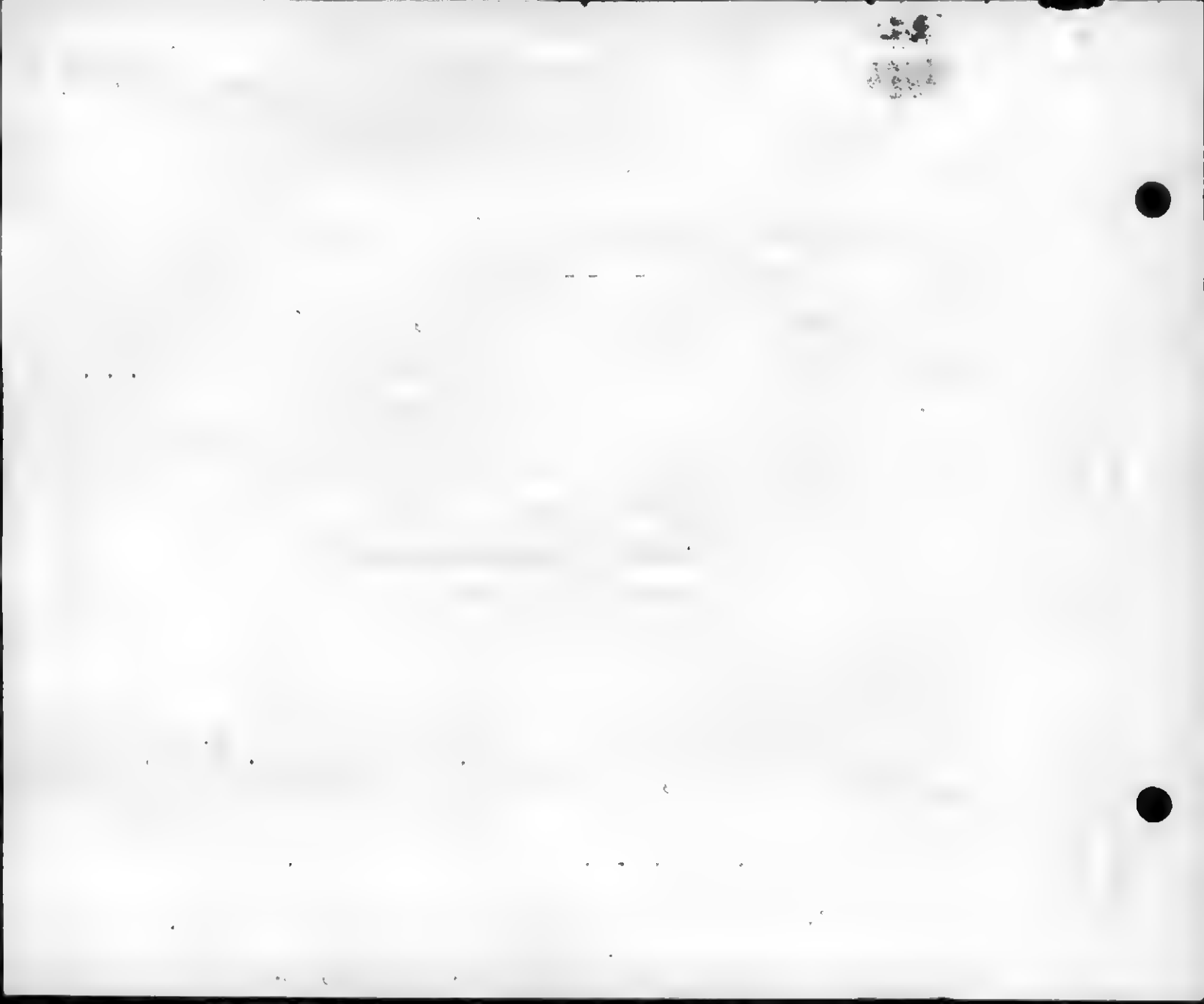
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01314

CERTIFICATE OF DEATH

01910

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3114 BARCLAY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle POINDEXTER Last POINDEXTER				4. DATE OF DEATH Month FEBRUARY Day 22 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 3, 1900	9. AGE (In years last birthday) 66 YES	IF UNDER 1 YEAR Months 30 Days 4		IF UNDER 24 HRS Hours 4 Min 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MONROE COUNTY, ALABAMA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACK POINDEXTER			14. MOTHER'S MAIDEN NAME MINERVA MAGTIE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO 233 14 42 81		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PASSIVE CONGESTION OF THE HEART DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH DAYS MONTHS YEARS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from FEB. 21 , 19 67 , to FEB. 22 , 19 67 , that (1) (we) last saw the deceased alive on FEB. 22 , 19 67 , and that death occurred at 205 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/23/67		
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.			22d. ADDRESS VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-27-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR <i>Turnell S. Oden</i>		ADDRESS ODEN FUNERAL HOME		25a. REC'D BY REGISTRAR DATE MAR 3, 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



CERTIFICATE OF DEATH

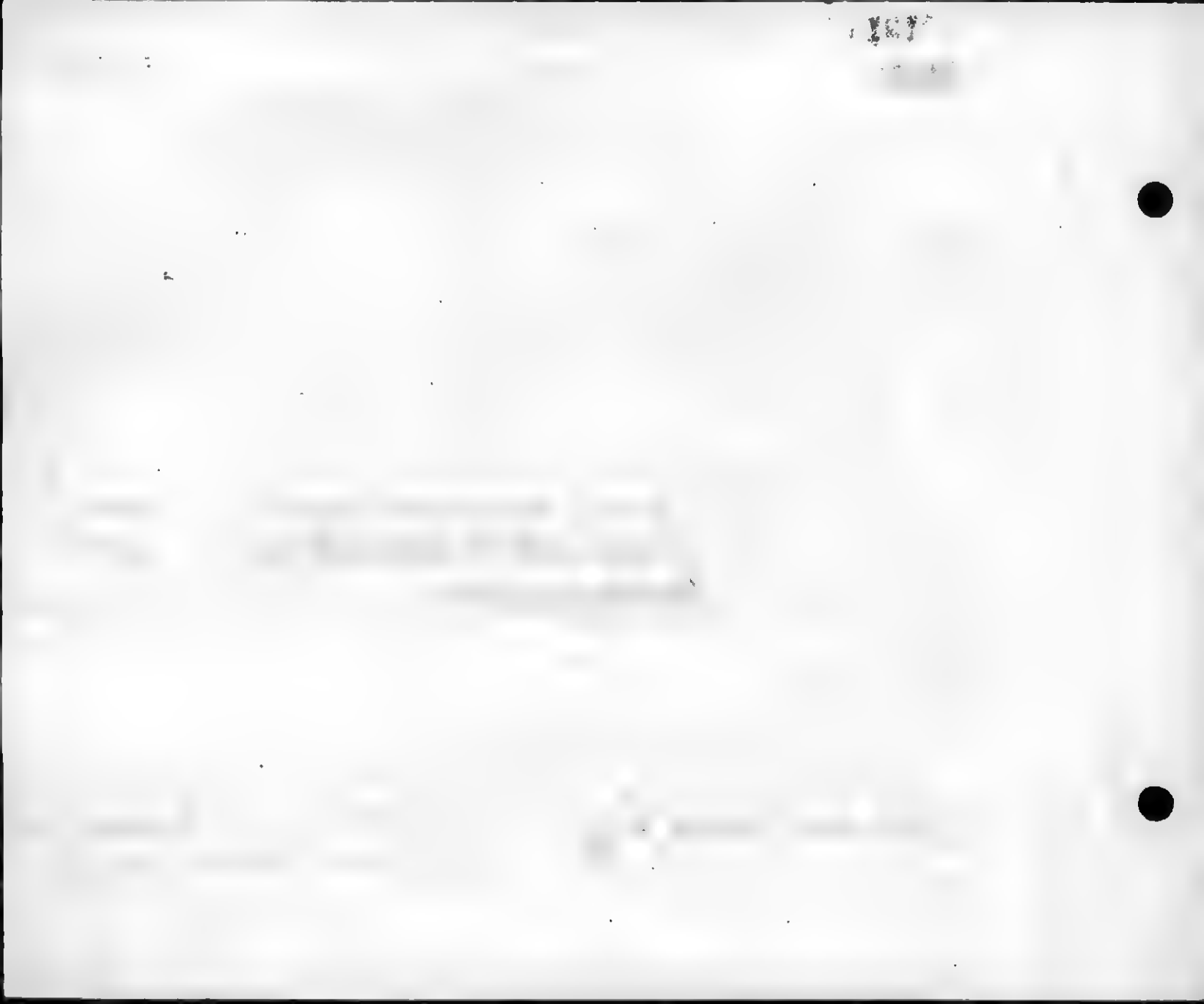
019115

01911

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>615 Chestnut Ave. Towson</u>		c. LENGTH OF STAY in lb. <u>YEARS</u> <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Good Women & Men's Home</u>		d. STREET ADDRESS <u>1502 Hollins ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Causey Polk</u>		4. DATE OF DEATH Month Day Year <u>February 17 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27 1878</u>
9. AGE (In years, last birthday) <u>88</u> yrs		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Liv. Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Sikesville, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Trusten Polk</u>		14. MOTHER'S MAIDEN NAME <u>Louise Dorsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>020-07-4335</u>	
17. INFORMANT <u>E. McElfresh</u>		Address <u>615 Chestnut Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarct</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>arteriosclerosis heart disease</u> DUE TO (c) <u>Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 20, 1958</u> , to <u>Feb. 17, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb. 17, 1967</u> , and that death occurred at <u>11:35 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Newland Edward Day</u>		22b. DATE SIGNED <u>February 18, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Newland Edward Day</u>		22d. ADDRESS <u>4-E-33rd St Baltimore Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Feb. 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Oliver</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Maryland 21204</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 20 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
2DM 1/65

01916

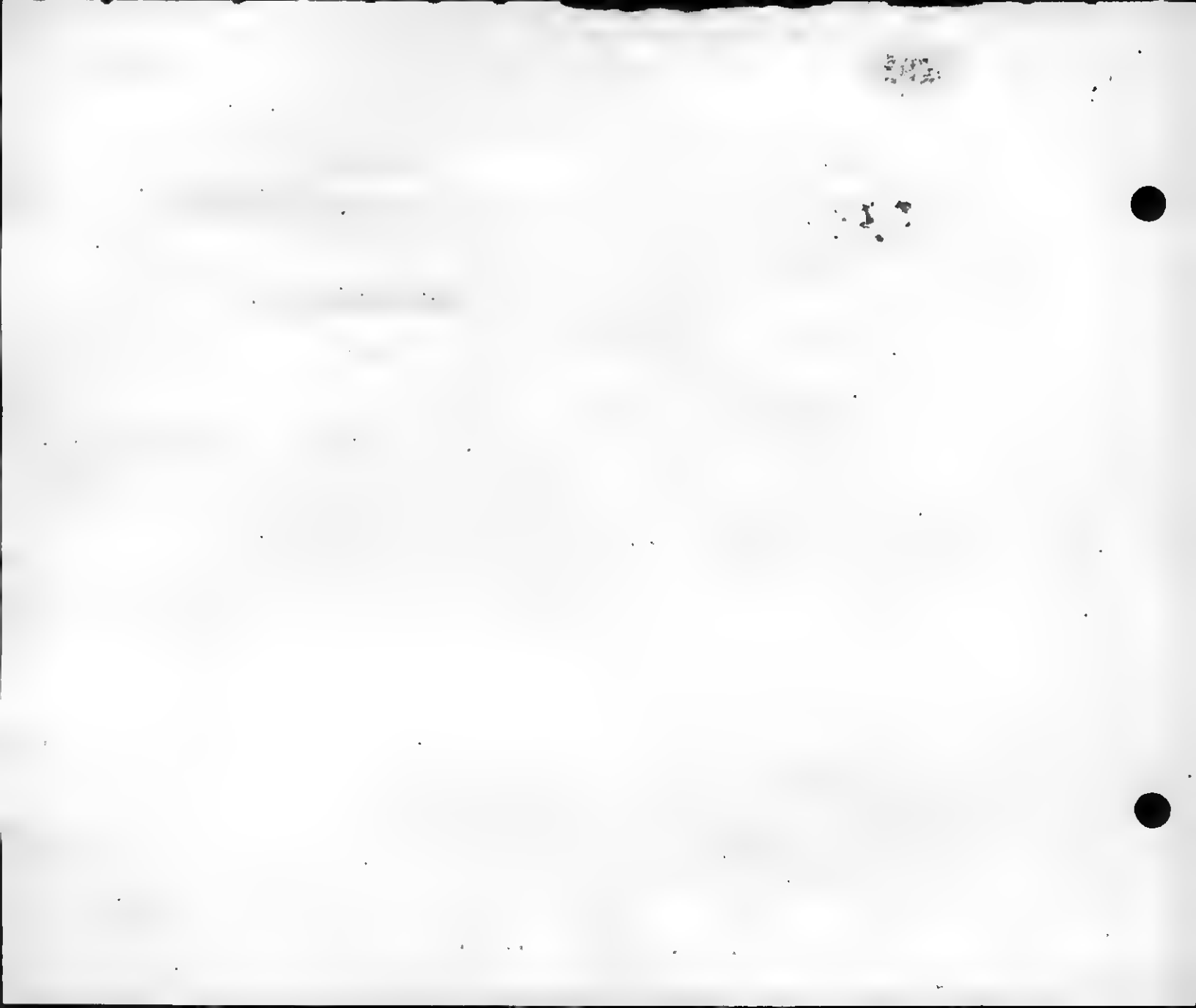
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01912

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>4</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Balto. County General Hospital</u>		d. STREET ADDRESS <u>5306 Belleville Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>N.M.I.</u> Last <u>POLUN</u>		4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/21/1917</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>Hillel Eisenberg</u>		14. MOTHER'S MAIDEN NAME <u>Brina ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFIRMANT <u>Mrs. Mindel Rudman, 5306 Belleville Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>possible pulm. embolism</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recent myocardial infarction</u> DUE TO (c) <u>congestive heart failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>2-3 wks</u> <u>2-3 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/21/67</u> , 19 <u>67</u> , to <u>2/15/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/15/67</u> , 19 <u>67</u> , and that death occurred at <u>8:40</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Joya</u>		22b. DATE SIGNED <u>2-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. JOYA</u>		22d. ADDRESS <u>B. E. G. H.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Mens</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>EEB 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. J. J.</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

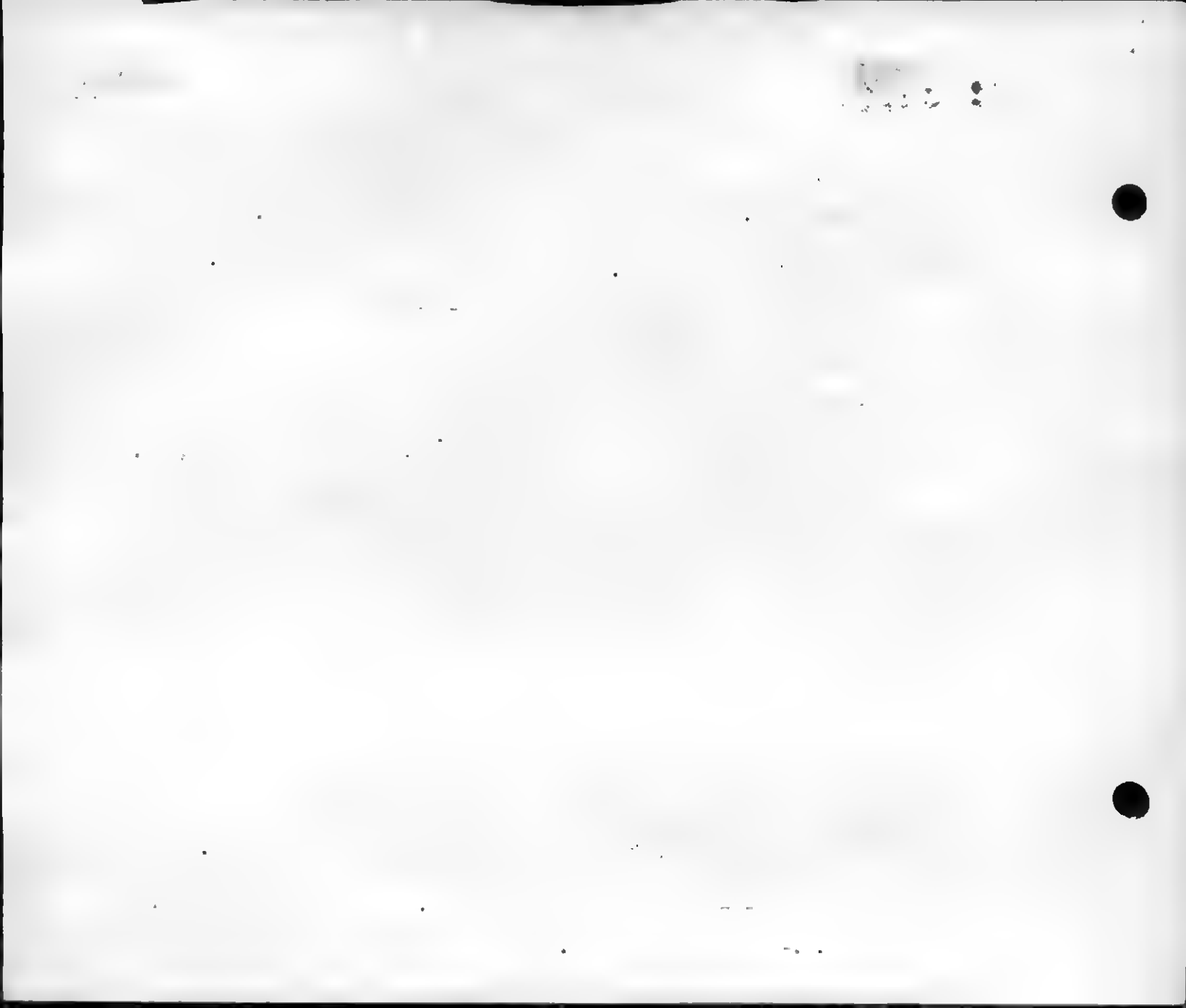
CERTIFICATE OF DEATH

01917

01913

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c LENGTH OF STAY IN 1b d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>14 Overbrook Rd.</u>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d STREET ADDRESS <u>14 Overbrook Rd.</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Anna W. Poske</u>				4 DATE OF DEATH Month Day Year <u>Feb. 4 1967</u>																	
5 SEX <u>F</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>8-20-90</u>		9 AGE (In years last birthday) <u>76</u> yrs <table border="1" style="float: right; width: 100px;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS		Months	Days	Hours	Min				
IF UNDER 1 YEAR		IF UNDER 24 HRS																			
Months	Days	Hours	Min																		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b KIND OF BUSINESS OR INDUSTRY 		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>													
13 FATHER'S NAME <u>Late - Henry Knapp</u>				14 MOTHER'S MAIDEN NAME <u>Late - Mary Klein</u>																	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO.		17 INFORMANT <u>MR. Henry Frei</u> Address <u>Box 41-Fork Road, Baldwin, Md.</u>															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH													
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)																	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>2/4</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> P.M., from causes and on the date stated above.																					
22a SIGNATURE <u>James N. Frederick</u>						22b DATE SIGNED <u>2/6/67</u>		22c PHYSICIAN'S NAME (Type) <u>James Frederick</u>		22d ADDRESS <u>1311 Francis Ave.</u>											
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b DATE THEREOF <u>2-8-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>													
24 FUNERAL DIRECTOR <u>Witzke F.D. - 4101 Edmondson Ave.</u>						25a REC'D BY REGISTRAR DATE <u>FEB 6 1967</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The low assures that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

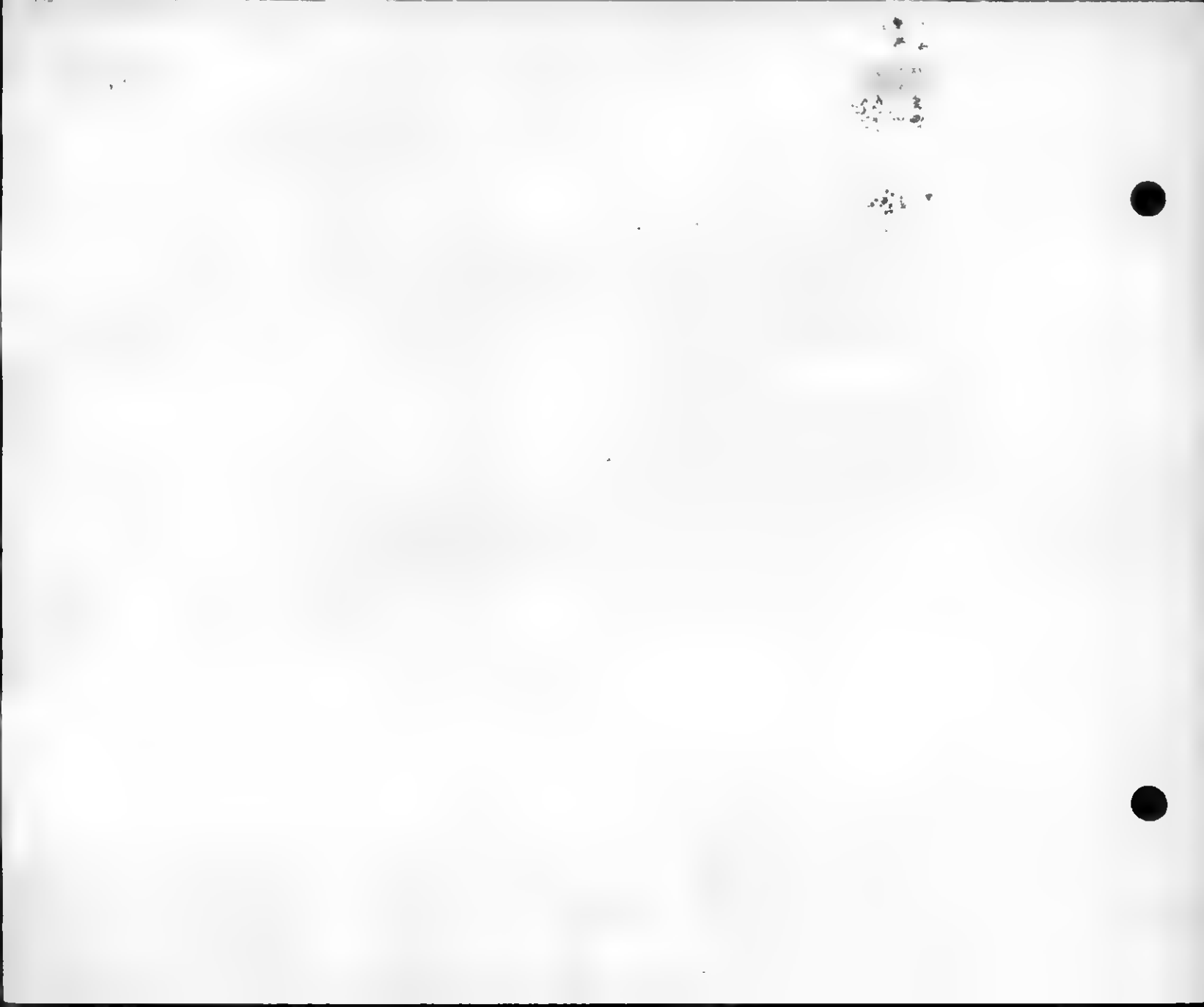
01914

FOR STATE
HEALTH DEPT.

01918

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Part 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTO MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution or Residence before admission) a. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4 C WESTWAY SOUTH				d. STREET ADDRESS 4 C WESTWAY SOUTH			
3 NAME OF DECEASED (Type or print) First Middle Last JOHN C. PULLIAM				4 DATE OF DEATH Month Day Year FEB 2 19 67			
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 27 1913		9 AGE (In years last birthday) 53	10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY MARTIN CO		11 BIRTHPLACE (State or foreign country) VA.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WALTER S. PULLIAM				14. MOTHER'S MAIDEN NAME MARY GORDON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNK		16. SOCIAL SECURITY NO. 223-16-7557		17. INFORMANT MARIE PULLIAM		Address ABOVE	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO A-S-C-V-DISEASE Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Notrol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M.B. Davis		EXAMINER'S NAME (Type) M.B. Davis MD-6800		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/6/67		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION (City or town) (County) (State) BALTO MD	
24 FUNERAL DIRECTOR J.G. CONNELLY SONS				ADDRESS 300 MACE		25a. REC'D BY REGISTRAR DATE FEB 7 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

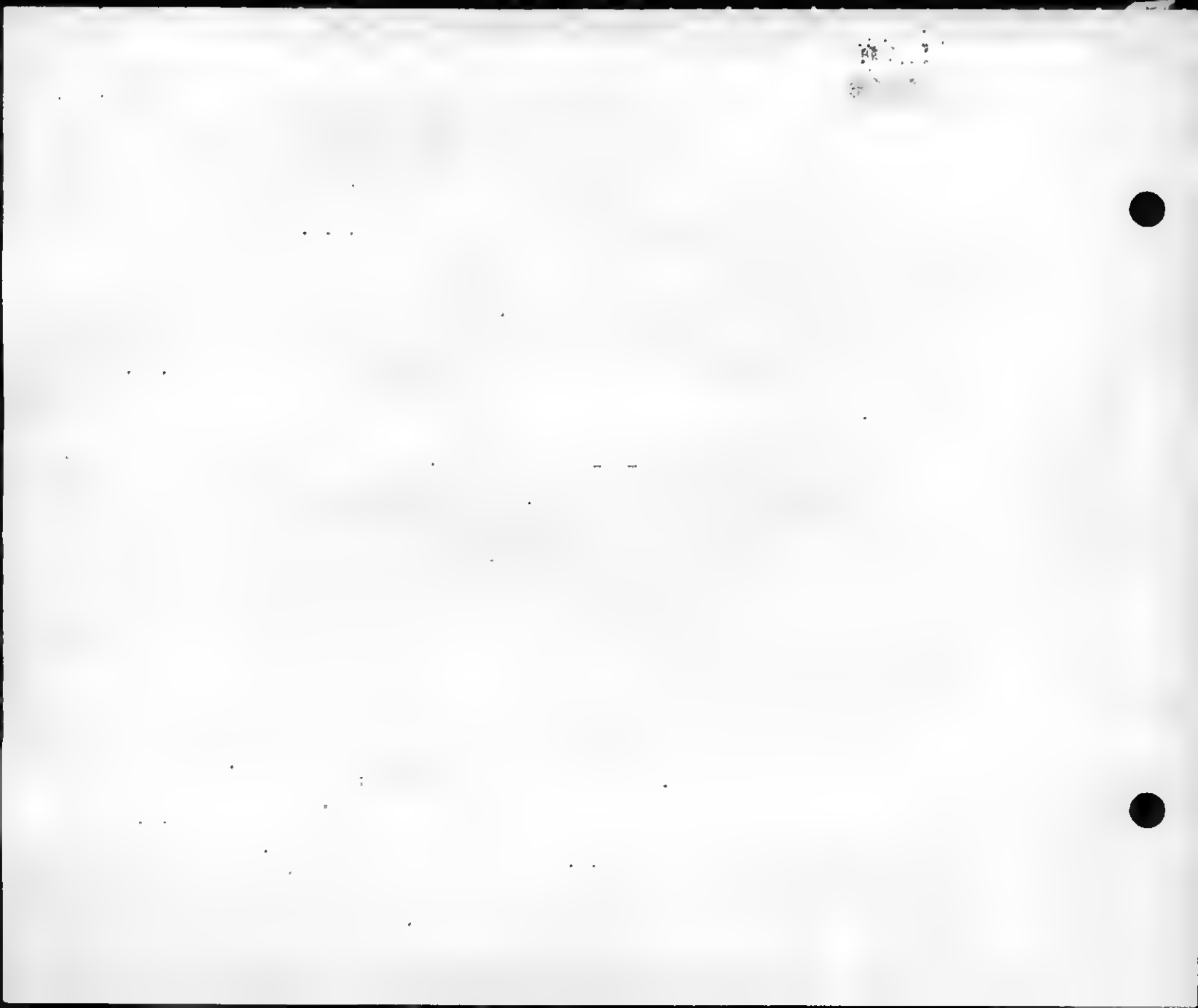
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01919

CERTIFICATE OF DEATH

01915

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c LENGTH OF STAY IN 1b 4yr9mth11dys		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Maryland		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d STREET ADDRESS Box 122- R.F.D. #3		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First John Middle = Last Purcell				4 DATE OF DEATH Month February Day 2 Year 19 67			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH ? 1877	9 AGE (In years and birthday) 89 yrs	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS Hours 0 Min. 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) construction worker		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Ireland		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Simon Purcell				14. MOTHER'S MAIDEN NAME Johanna Mascall			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 186-03-8943		17 INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4x1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Arteriosclerosis, generalized DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from April 18 19 62 to Feb. 2, 1967 , that the (we) last saw the deceased alive on Feb. 2 19 67 , and that death occurred at 15 M, from causes and on the date stated above							
22a. SIGNATURE Stella Wachslor M.D.				a. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 2-2-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslor, M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/4/1967		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CATHEDRAL CEM.		23d. LOCATION (City or Town) (County) (State) TRENTON N.J.	
24. FUNERAL DIRECTOR John M. Taylor Sons Inc. Spotsylvania Md.				25a. REC'D BY REGISTRAR DATE FEB 8 1967		25b. REGISTRAR'S SIGNATURE John M. Taylor	

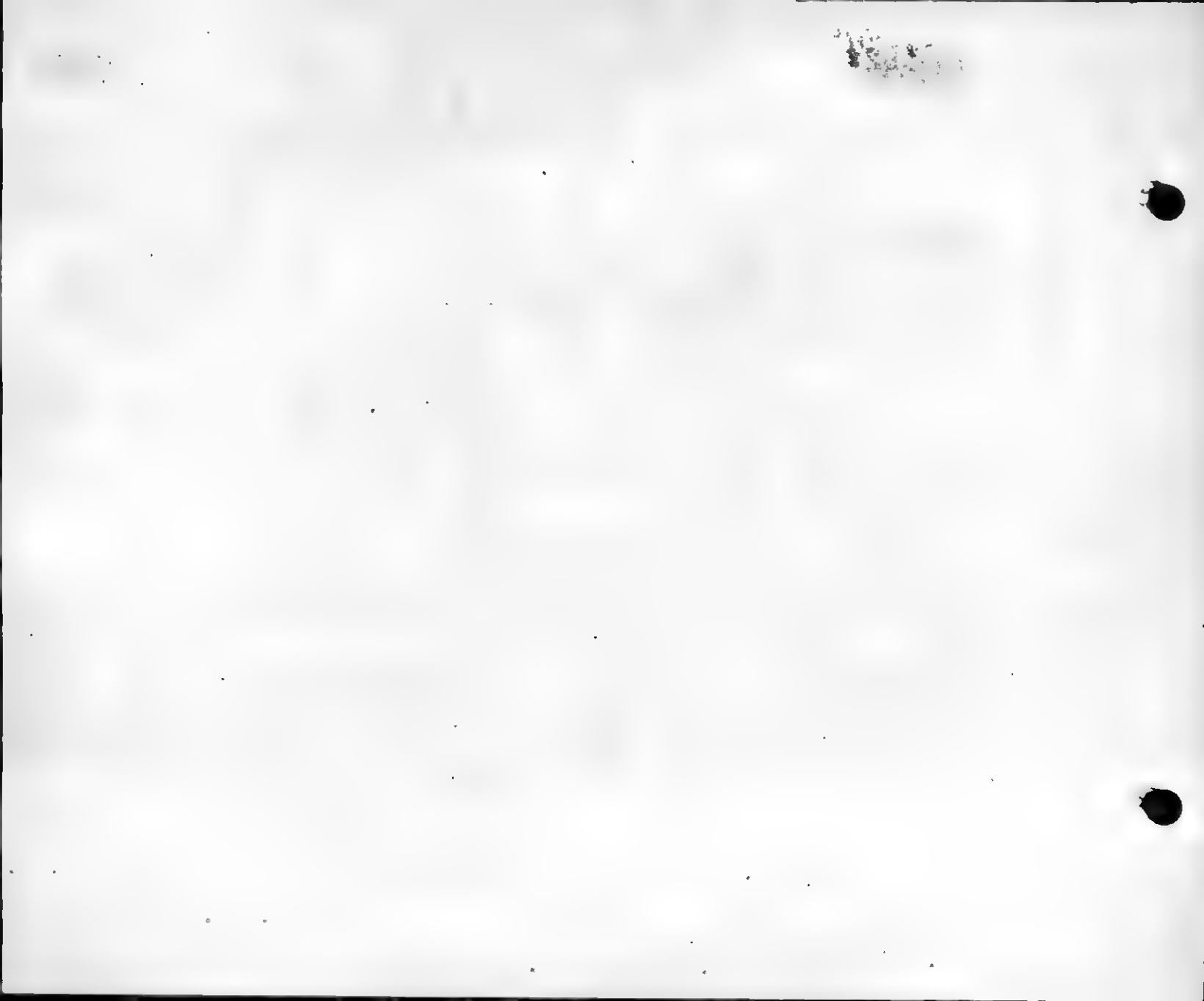


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK c. LENGTH OF STAY IN 1b 27 YRS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1900 WASHINGTON ROAD				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 21222 d. STREET ADDRESS 1900 WASHINGTON ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MARIE DEITZ RABER 5. SEX FEMALE 6. COLOR OR RACE CAUCASIAN 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 11/29/1908 9. AGE (In years last birthday) 58 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA				4. DATE OF DEATH 2/14/1967 19 13. FATHER'S NAME GEORGE DEITZ 14. MOTHER'S MAIDEN NAME EMMA J. AILSHIRE 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. NONE 17. INFORMANT JACK RABER (AS IN 2 ABOVE)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STRANGULATION by HANGING - CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Heavy fall from attic rafters 20c. TIME OF INJURY Month, Day, Year 4:15 a.m. 2-14-67 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Dundalk (County) Baltimore (State) MD.											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE MELVIN B. DAVIS M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) MELVIN B. DAVIS 6800 M. DUNDALK BAL. CO. 22. DATE SIGNED 2/16/67											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 2/17/67 23c. NAME OF CEMETERY OR CREMATORY OAKLAWN 23d. LOCATION (City, town or county) BALTO. CO. MARYLAND 24. FUNERAL DIRECTOR W. B. BROOKS BRADLEY, DUNDALK, MD. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge DATE FEB 17 1967											



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01921

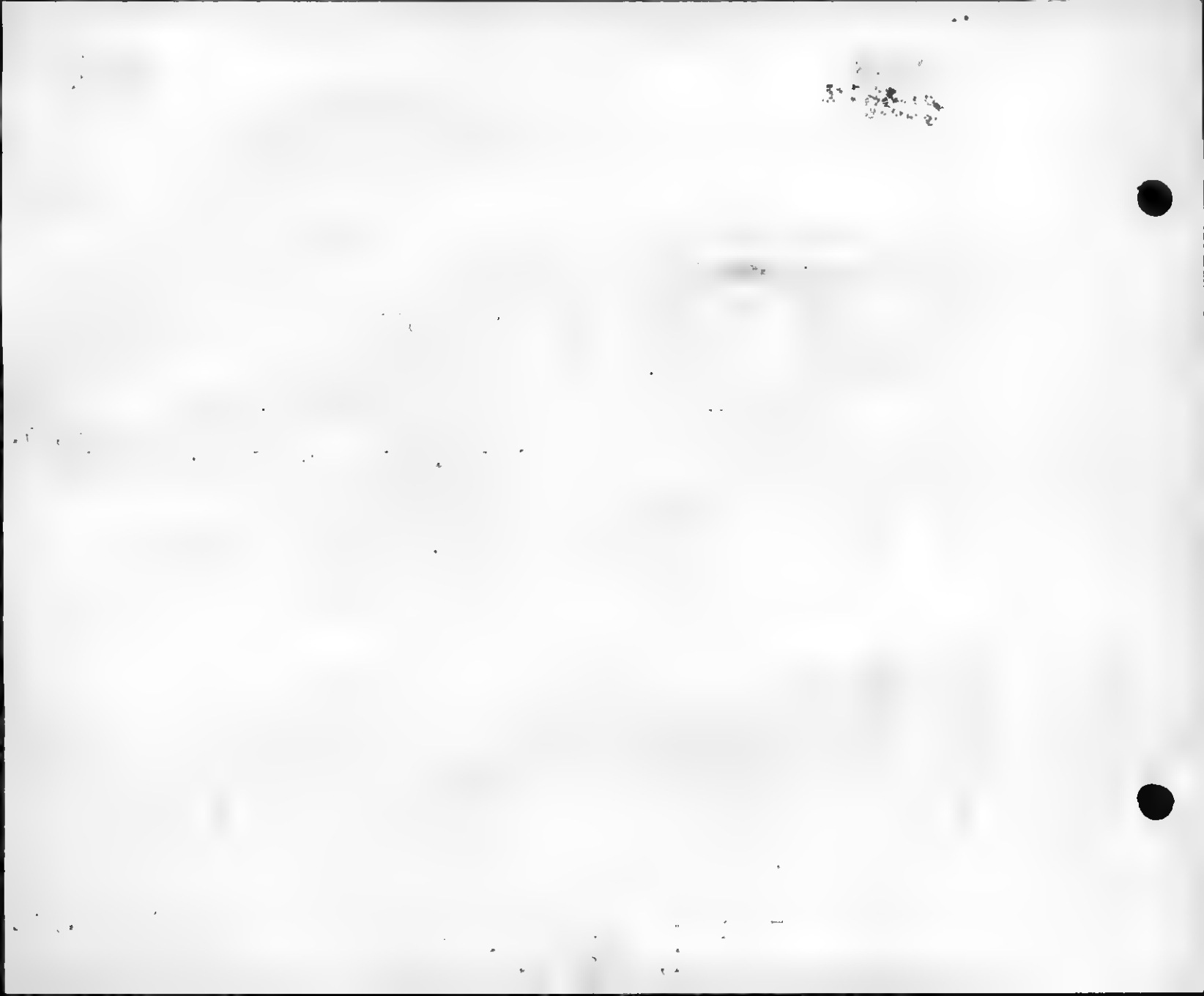
CERTIFICATE OF DEATH

01917

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 21224	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 702 South Highland Avenue	
3. NAME OF DECEASED (Type or print) Katherine Ramsauer First Middle Last		4. DATE OF DEATH February 4, 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1905
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anton Wild		14. MOTHER'S MAIDEN NAME Bertha Weisinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Carl F. Holtz		Address 8E Hillcrest Circle Rochester, N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral artery thrombosis DUE TO (b) Arteriosclerosis, generalized DUE TO (c) Portal cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (if) (this hospital) attended the deceased from January 22, 1967 , to February 4, 1967 , that (he) (we) last saw the deceased alive on February 4, 1967 , and that death occurred at 8:05 A.M. from causes and on the date stated above.			
22a. SIGNATURE Ramon P. Lopez		22b. DATE SIGNED February 4, 1967	
22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez, M. D.		22d. ADDRESS 7620 York Road, Towson 4, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-7-67	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	23d. LOCATION (City or Town) (County) (State) 4701 German Hill Rd., Md.
24. FUNERAL DIRECTOR Charles S. Jiles		25. REC'D BY REGISTRAR Charles Judge	
26. ADDRESS 901 S. Conkling St. Balto., 21224 Md.		DATE FEB 7 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01922

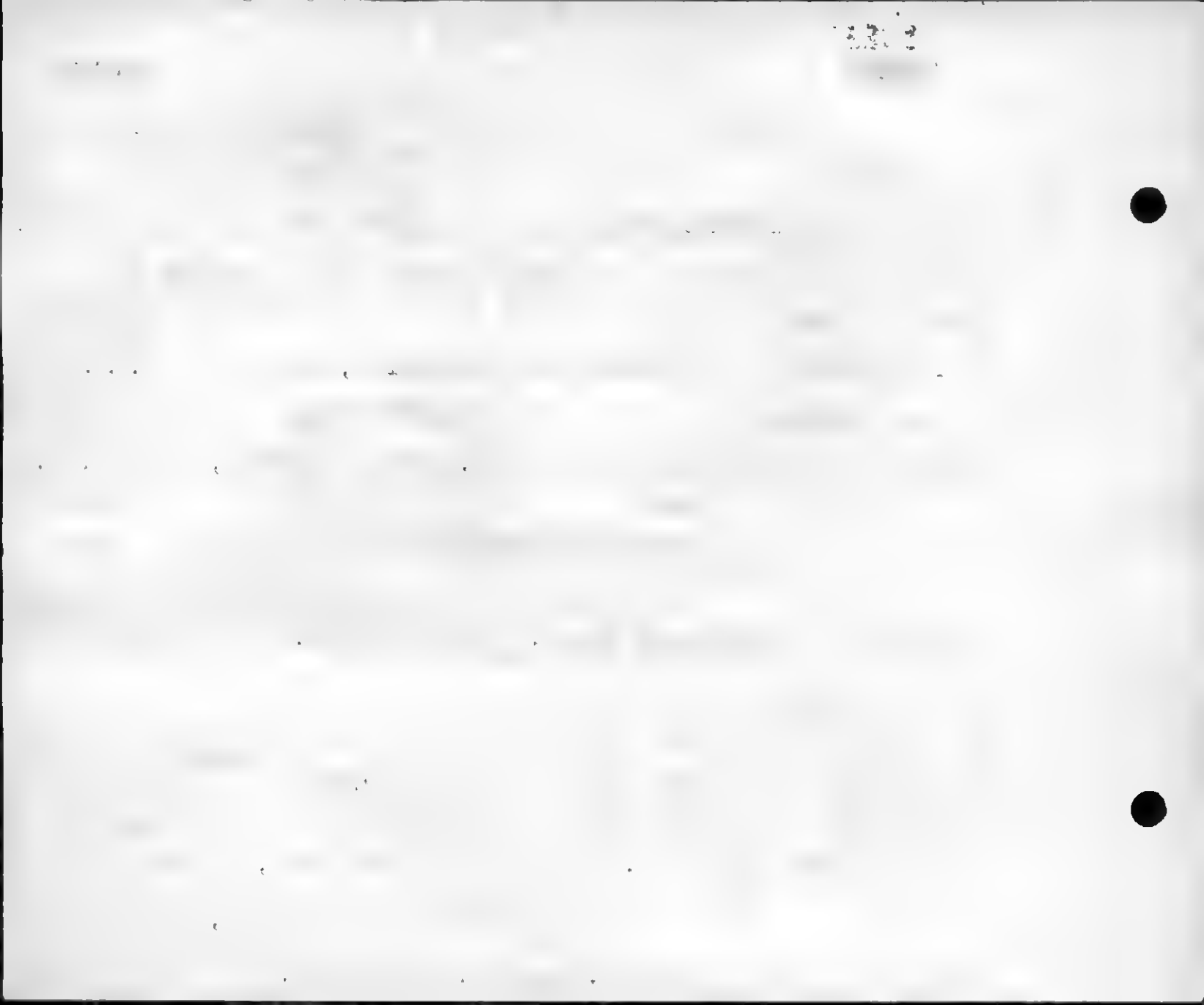
CERTIFICATE OF DEATH

01918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 126 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 71 WINTERS LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle WILLIAM Last RANDALL				4. DATE OF DEATH Month FEBRUARY Day 14 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/07		9. AGE (In years last birthday) yrs 59	IF UNDER 1 YEAR Months Days Hours Mm	IF UNDER 24 HRS Hours Mm
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY DELIVERY TRUCK		11. BIRTHPLACE (County & State, or foreign country) CATONSVILLE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LLOYD RANDALL				14. MOTHER'S MAIDEN NAME Minerva STEWART			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW II		16. SOCIAL SECURITY NO 215 12 78 46		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) UREMIA DUE TO (b) ARTERIOLAR NEPHROSCLEROSIS DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE Conditions: any, which gave rise to immediate cause (a), stating the underlying cause lost						INTERVAL BETWEEN ONSET AND DEATH MONTHS MONTHS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE. DIABETES MELLITUS.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 10/11/66 , 19 66 , to 2/14/67 , 19 67 , that the (we) last saw the deceased alive on 2/14/67 , 19 67 , and that death occurred at 9:40A M, from causes and on the date stated above.							
22a. SIGNATURE George Dudas				ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/14/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/17/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR 55B 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

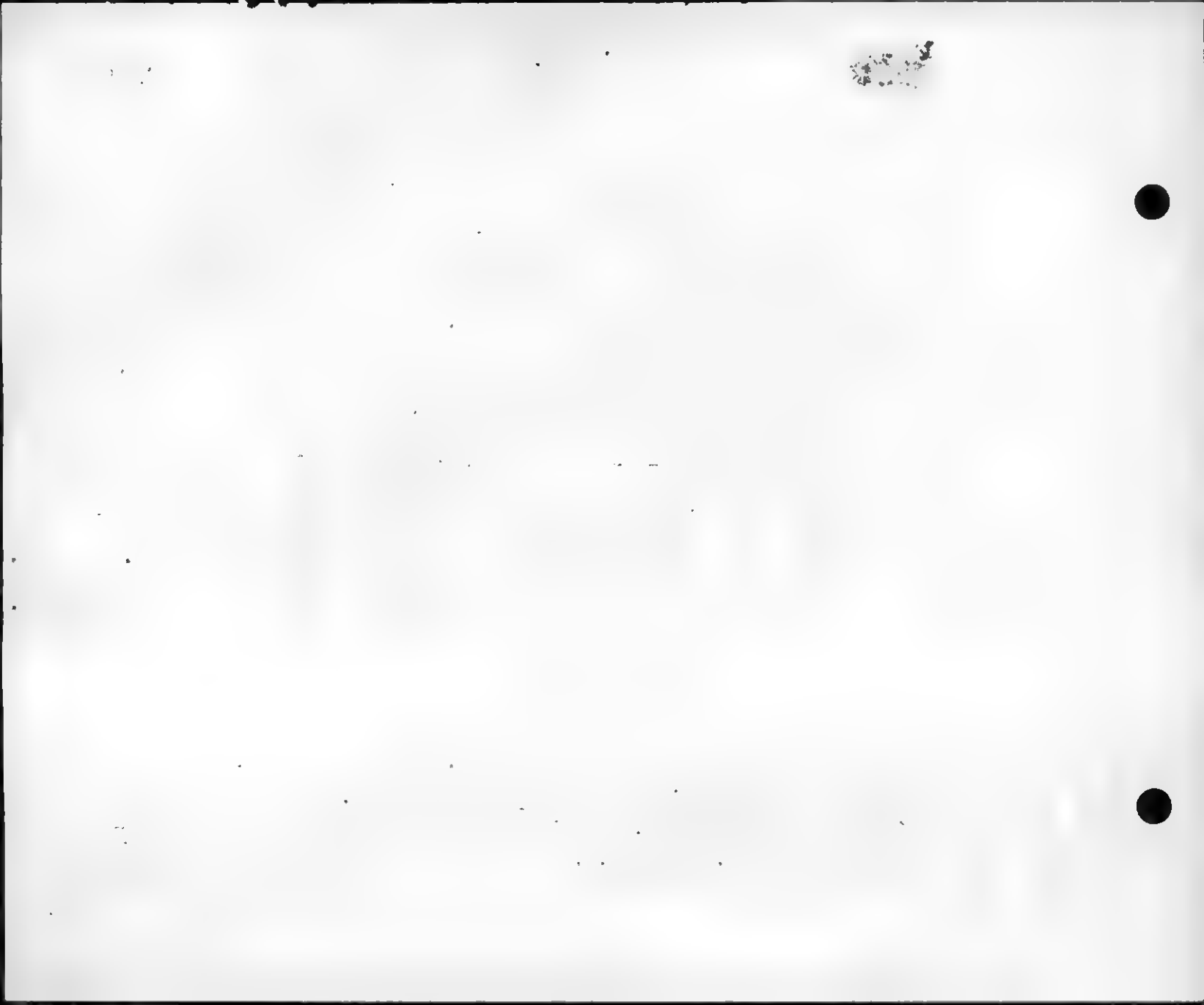
01923

CERTIFICATE OF DEATH

01919

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 3mth11dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Devine/Allen/Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Otis Middle Reagan Last Reagan				4. DATE OF DEATH Month February Day 2 Year 19 67					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1888			
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		10. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Archibald				14. MOTHER'S MAIDEN NAME Georganna Blades					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 214-18-2974		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC CARDIOVASCULAR HEART DTS. 20 yrs. DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED 20 yrs.							INTERVAL BETWEEN ONSET AND DEATH ACUTE		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema and pulmonary fibrosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day Year Hour 0 a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from Oct. 18, 1966 to Feb. 2, 1967 that (2) (we) last saw the deceased alive on Feb. 2, 1967 , and that death occurred at 10:50 M, from causes and on the date stated above.									
22a. SIGNATURE Anthony J. Young, M.D.				22b. DATE SIGNED 2-2-67		22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.			
22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 2/10/67		23c. NAME OF CEMETERY OR CREMATORY ST. Johns		23d. LOCATION (City or Town) (County) (State) Howard Co. Md.		
24. FUNERAL DIRECTOR E. S. Mac Nabb				ADDRESS Balto 21228 MD		25a. REC'D BY REGISTRAR DATE FEB 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

THE HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

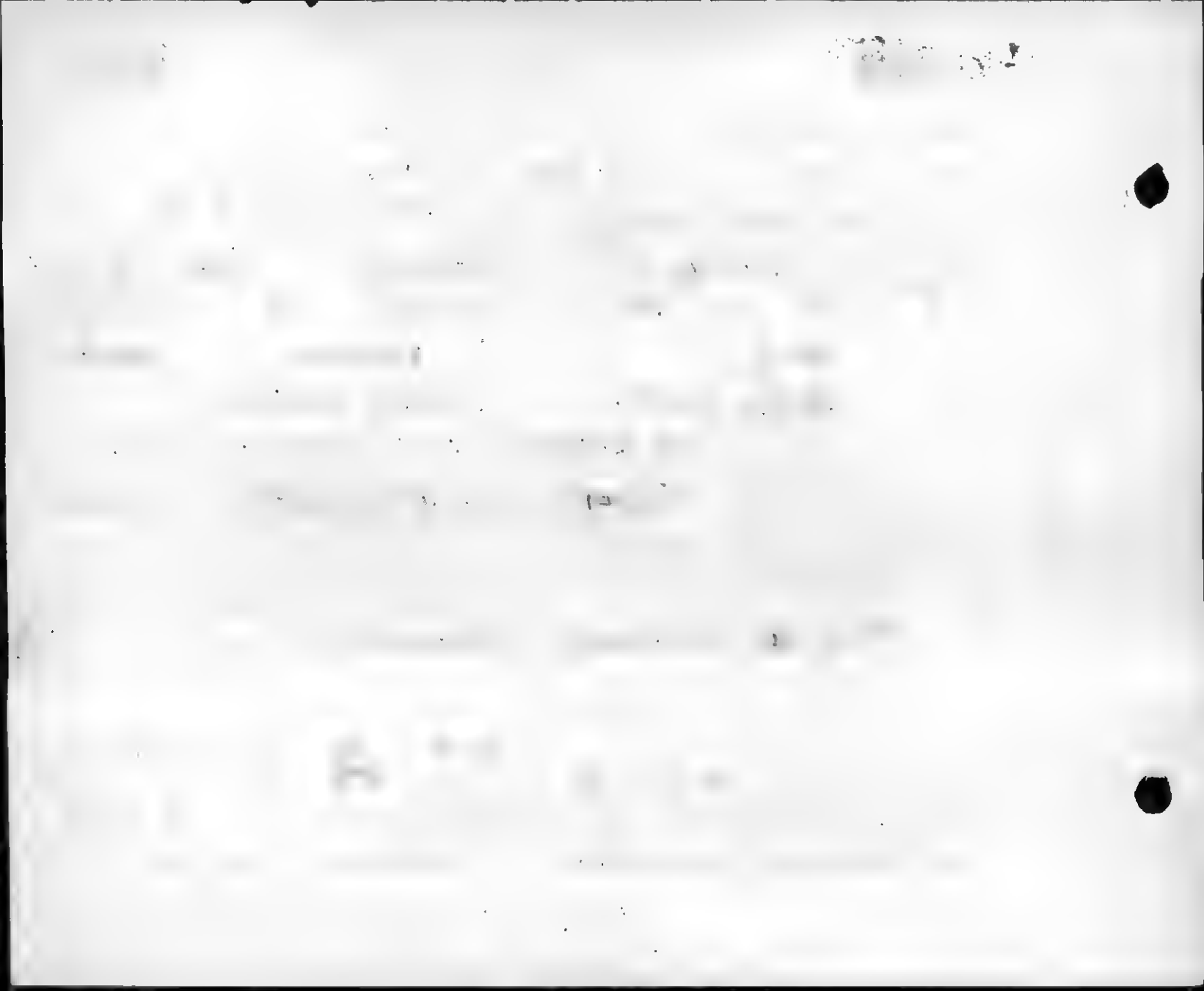


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01924 CERTIFICATE OF DEATH 01920

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 120 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 21217 d. STREET ADDRESS 1143 N. Mount St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Viola First Middle Last 4. DATE OF DEATH Feb 1 1967 Month Day Year		5. SEX F 6. COLOR OR RACE C 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) huf. 10b. KIND OF BUSINESS OR INDUSTRY Virginia 11. BIRTHPLACE (County & State, or foreign country) USA 12. CITIZEN OF WHAT COUNTRY?		9. AGE (in years last birthday) 75 yrs. Months Days Hours Min. IF UNDER 1 YEAR IF UNDER 24 HRS.	
13. FATHER'S NAME John Watty 14. MOTHER'S MAIDEN NAME Mary Shelton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 219-30-8374 16. SOCIAL SECURITY NO. 219-30-8374 17. INFORMANT Records, Mt. Wilson State Hospital Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculous Meningitis 002.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Minimal Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 5mo. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 10-4 , 19 66 , to 2-1 , 19 67 , that (I) (we) last saw the deceased alive on 2-1 , 19 67 , and that death occurred at 2:20 PM, from the causes and on the date stated above.	
22a. SIGNATURE Wm. Newcomer 22b. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent 22c. ADDRESS Mount Wilson, Maryland		22d. DATE SIGNED 2-1-67 M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-6-67 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Ch. 23d. LOCATION (City, town or county) (State) Arbutus, Md		24. FUNERAL DIRECTOR George A. Klon 1346 N. Calhoun St. 25a. REC'D BY REGISTRAR DATE FEB 3 1967 25b. REGISTRAR'S SIGNATURE Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01925

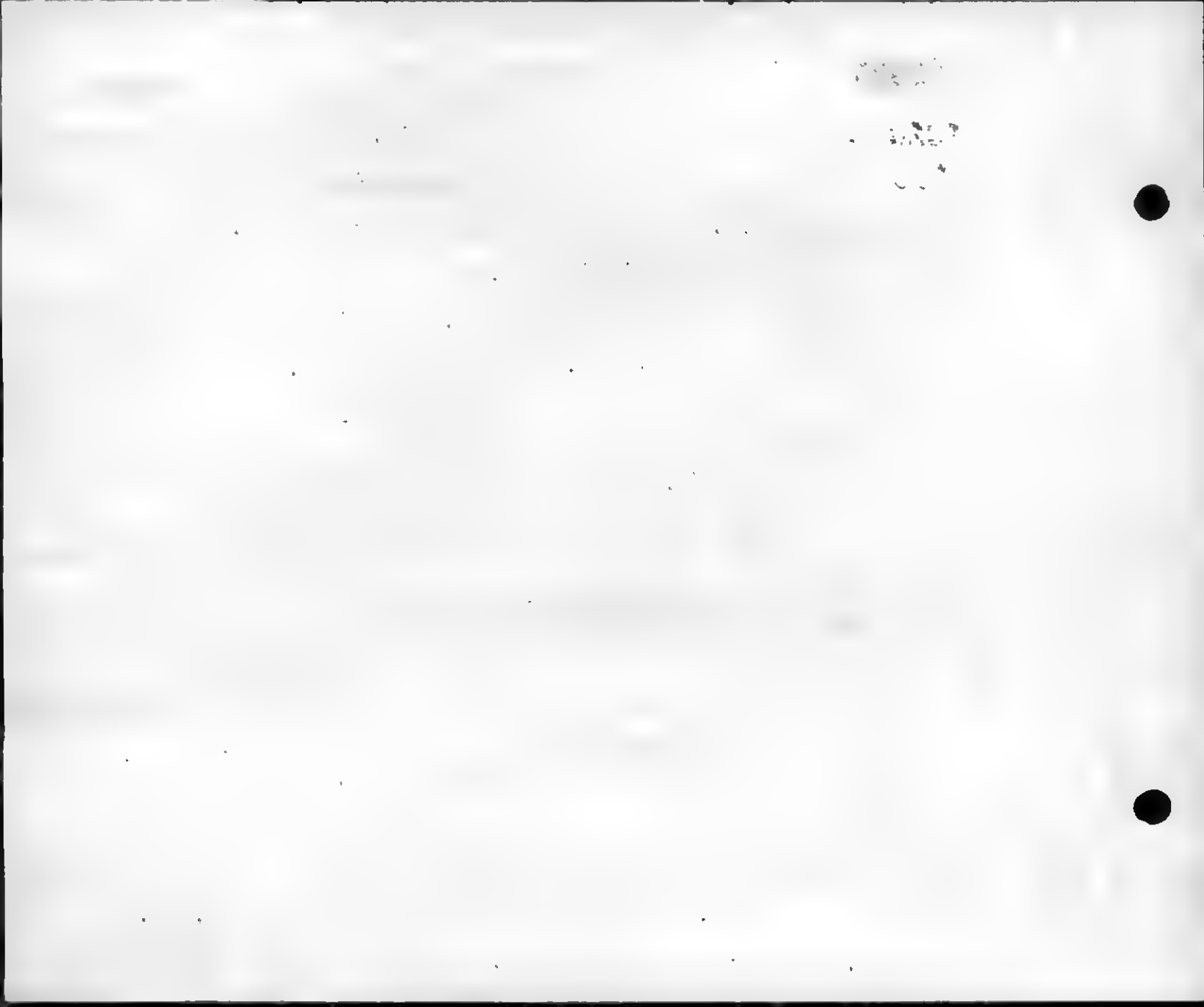
CERTIFICATE OF DEATH

01921

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut an Residents before adm ssion) a. STATE <u>Md.</u> b COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c LENGTH OF STAY IN 1b			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>601 Edmondson Ave.</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>William</u> Last <u>Reichelt</u>				4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>19 67</u>			
5 SEX <u>male</u>		6 COLOR OR RACE <u>white</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Aug. 23, 1905</u>	
9 AGE (In years last birthday) <u>61</u> yrs		10 UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min <u>14</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CIT ZEN OF WHAT COUNTRY? <u>USA</u>	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furnace tender</u>				10b KIND OF BUSINESS OR INDUSTRY <u>Refining Co.</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	
13 FATHER'S NAME <u>Arthur Reichelt</u>				14 MOTHER'S MAIDEN NAME <u>Mary Vetter</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16 SOCIAL SECURITY NO <u>212101827</u>		17 INFORMANT <u>Mrs Elsie Reichelt</u> Address <u>same</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Squamous cell Carcinoma left neck</u> (b) <u>(primary unknown)</u> and (c) <u>cerebral extension (Probably lung)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						INTERVAL BETWEEN ONSET AND DEATH <u>14 mos.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>65</u> , to <u>Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>27 Jan.</u> 19 <u>67</u> , and that death occurred at <u>3 A.</u> M. from causes and on the date stated above							
22a SIGNATURE <u>Arthur G. Siwinski</u>				22b. DATE SIGNED <u>25 Feb 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Arthur G. Siwinski</u>	
22d. ADDRESS <u>836 Park Ave</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
<u>buried</u>		<u>2/28/67.</u>		<u>Baltimore Cemetery</u>		<u>Baltimore, Md.</u>	
24 FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>				25a REC'D BY REGISTRAR <u>FEB 27 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2. should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01926

Inter #8 Film

CERTIFICATE OF DEATH

01922

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. STATE <u>Maryland</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> d. LENGTH OF STAY IN b. <u>1 year</u> e. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>308 Highmeadow Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> d. STREET ADDRESS <u>308 Highmeadow Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>EDGAR A. REILLY, Sr.</u>		4. DATE OF DEATH <u>February 11, 1967</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 6, 1890</u>		9. AGE (In years last birthday) <u>77 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles H. Reilly</u>				14. MOTHER'S MAIDEN NAME <u>Anna Lee Jacobs</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-10-4258</u>				17. INFORMANT <u>Mrs. Beulah M. Reilly</u> Address <u>308 Highmeadow Rd. Reisterstown, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Carcinoma - st. eye</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Metastasis to lung.</u> DUE TO (b) <u>cachexia</u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>											
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-65</u> to <u>2-11-67</u>, that (I) (we) last saw the deceased alive on <u>2-11-67</u> and that death occurred at <u> </u> M. from the causes and on the date stated above.															
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>2-13-67</u>							
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell M.D.</u>				22d. ADDRESS <u>Reisterstown, Md.</u>				22e. REGISTRAR'S SIGNATURE <u>[Signature]</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/14/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>				23d. LOCATION (City, town or county) <u>Woodlawn, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Eichhardt</u>				ADDRESS <u>Owings Mills, Md.</u>				25a. REC'D BY REGISTRAR <u> </u>				25b. REGISTRAR'S SIGNATURE <u>Charles Jude</u>			
DATE <u>FEB 14 1967</u>				25c. REGISTRAR'S SIGNATURE <u> </u>											

233



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01927

CERTIFICATE OF DEATH

Items 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

01923

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a STATE Maryland b COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa, 6400 Bellona Avenue		e. STREET ADDRESS 3307 Bloomingdale Rd.	
3. NAME OF DECEASED (Type or print) Mary Elizabeth E. Reiter		4. DATE OF DEATH Month 2 Day 10 Year 1967	
5 SEX F	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/11/1883
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months 2 Days 10 Hours 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13 FATHER'S NAME Nicholas Reiter		14. MOTHER'S MAIDEN NAME Mary Louise Kobhler	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO	
17. INFORMANT Address			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of urinary tract DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 4 mo. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m 19		20d INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1952 to 2/10 , 19 67 that (I) (we) last saw the deceased alive on 2/6 , 19 67 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert A. Reiter, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 606 Edmondson Ave. - 28	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2/13/67	
23c. NAME OF CEMETERY OR CREMATORY Cathedral		23d. LOCATION (City, town, or county) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Farley Caronough		25a. REC'D BY REGISTRAR DATE FEB 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

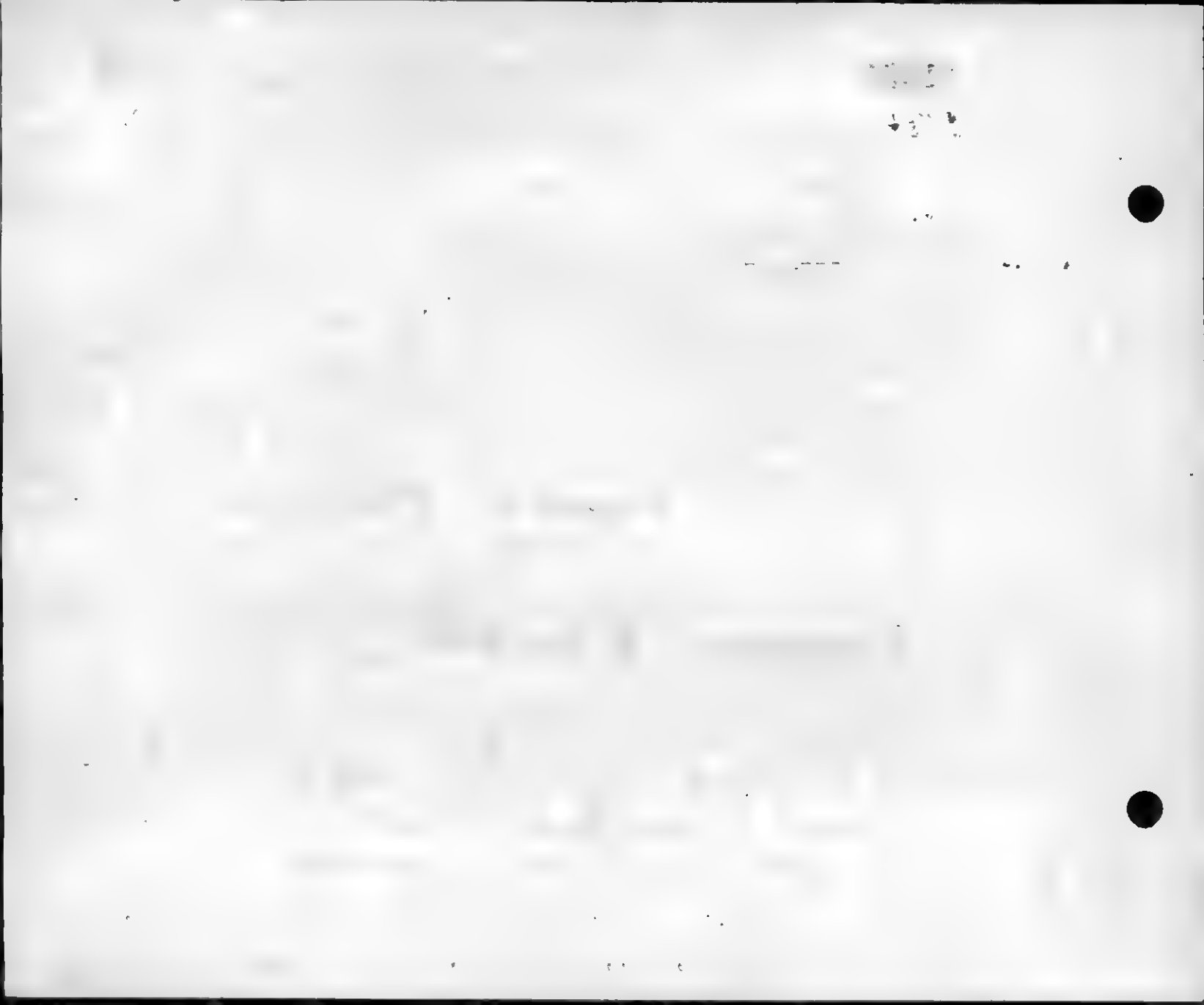
VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01928

01924

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GARRISON</u>		c. LENGTH OF STAY IN ID <u>3 mo.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FOXLEIGH NURSING HOME</u>				d. STREET ADDRESS <u>60 YORKWAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Carl Henning</u> <u>RENSTROM</u>				4. DATE OF DEATH Month Day Year <u>2</u> <u>22</u> <u>67</u> <u>19</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1879</u>	9. AGE (in years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>Sweden</u> <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>Lars Renstrom</u>				14. MOTHER'S MAIDEN NAME <u>Louise (unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-01-8826</u>		17. INFORMANT <u>GEORGE RENSTROM</u> Address <u>60 YORKWAY</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Prostate</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-26</u> , 19 <u>66</u> , to <u>2-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-21</u> , 19 <u>67</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>David I. Miller</u>				22b. DATE SIGNED <u>FEB 22-67</u>		22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>	
22d. ADDRESS <u>Union Rd</u>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>2/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RURAL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>SOUTHBORO, MASS.</u>	
24. FUNERAL DIRECTOR <u>Walter Brooks Bradley, Inc., Dundalk, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>FEB 24 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

01929

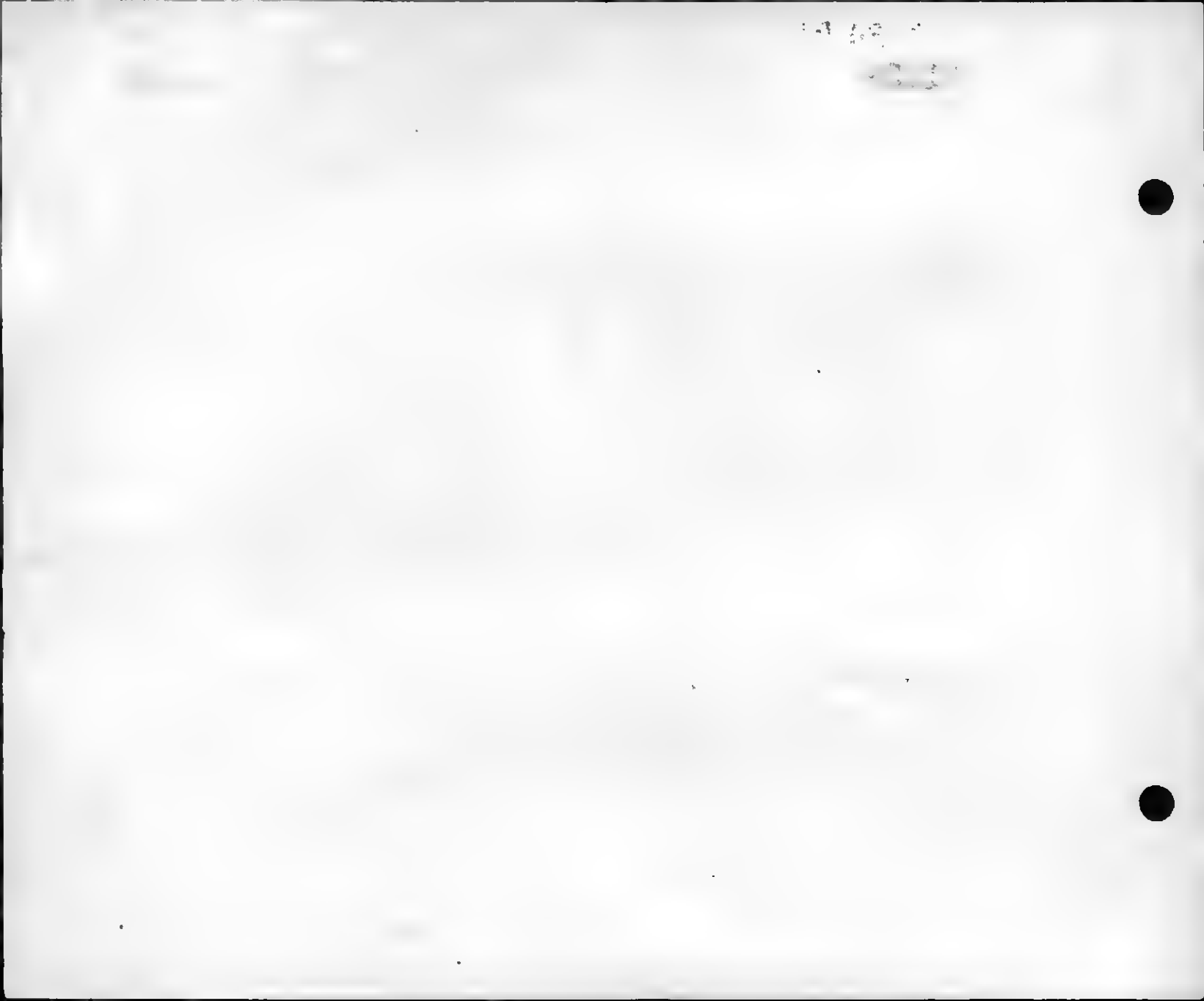
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01925

TO NOTIFY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Harford</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c LENGTH OF STAY IN 1b <u>15</u> yrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford State Hospital</u>		e STREET ADDRESS <u>1737 Marshall St.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>John</u> <u>Blanchard</u>		4 DATE OF DEATH Month Day Year <u>Feb</u> <u>23</u> <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/2/44</u>
9 AGE (In years last birthday) <u>22</u> yrs.		10 UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Hagerstown</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John</u>		14 MOTHER'S MAIDEN NAME <u>LEAH</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>asphyxia due to aspiration of</u> <u>253</u> DUE TO <u>Hard boiled Egg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>mental Retardation</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>microcephalic</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Deceased grabbed a hard boiled egg & stuffed it in his mouth</u>	
20c TIME OF INJURY Month, Day, Year <u>7:45 am Feb 23 1967</u>	20d INJURY OCCURRED Where <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street office bldg, etc.) <u>Rosewood State Hosp</u>	20f (City or town) (County) (State) <u>Harford</u> <u>Harford</u> <u>Md.</u>
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A.D. Caples</u> M.D.		22. DATE SIGNED <u>2-23-67</u>	
EXAMINER'S NAME (Type) <u>D.D. CAPLES, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>2-26-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Hagerstown, Md.</u>
24 FUNERAL DIRECTOR <u>Minnich Funeral Home, Hagerstown, Md.</u>		25a REC'D BY REGISTRAR DATE <u>FEB 27 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01930

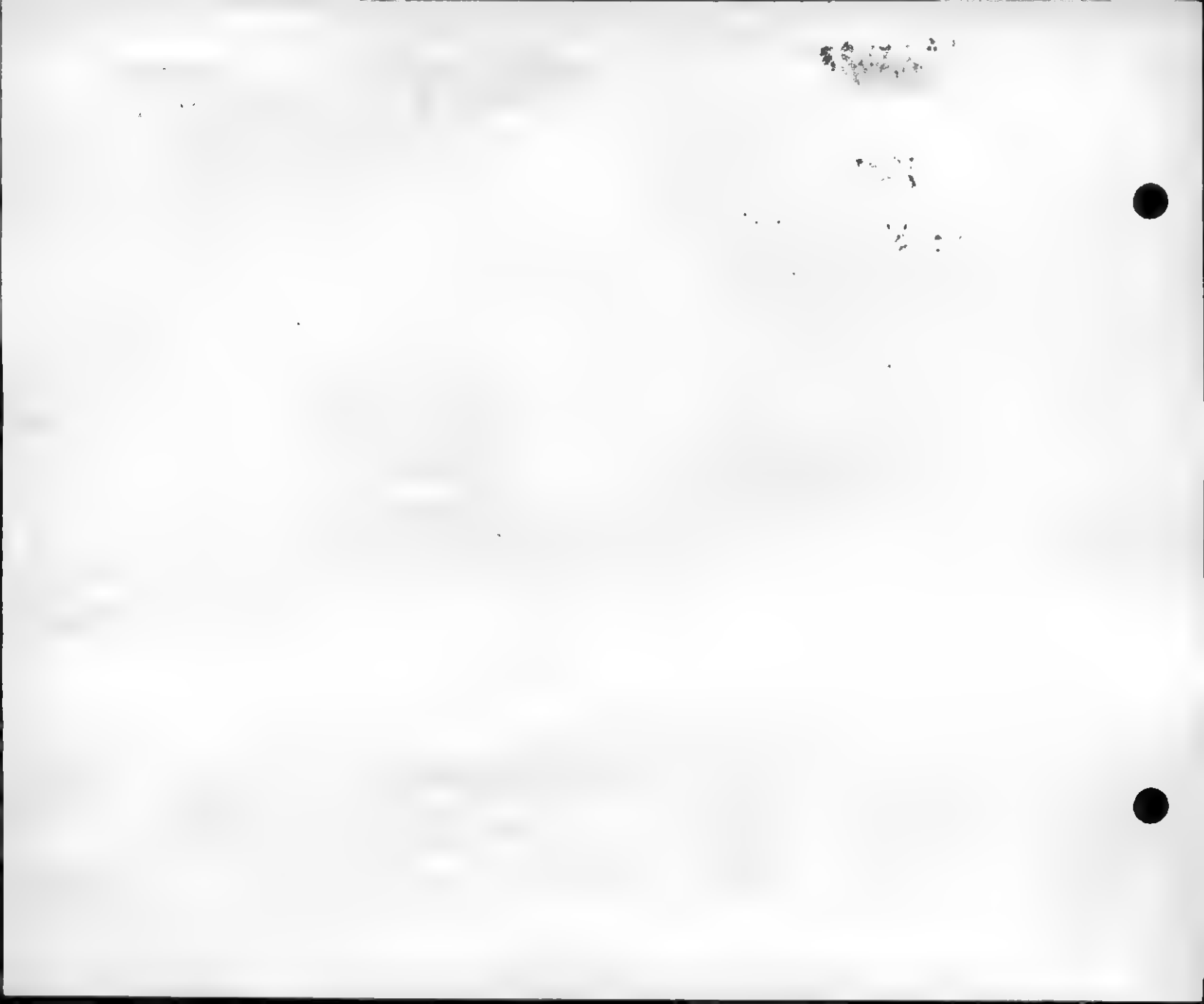
CERTIFICATE OF DEATH

01926

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE MARYLAND b COUNTY _____			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ACCEYSVILLE		c LENGTH OF STAY IN 1b 19 MONTHS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MASONIC HOME				d STREET ADDRESS 4703 HAMPNETT AVE		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First EMMA Middle M Last RICHARDSON				4 DATE OF DEATH Month FEB Day 1 Year 1967			
5 SEX FE	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/28/1883	9 AGE (in years last birthday) 83 yrs	f UNDER 1 YEAR Months _____ Days _____		g UNDER 24 HRS Hours _____ Min. _____
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U-S	
13 FATHER'S NAME LEWIS T. BENNETT				14 MOTHER'S MAIDEN NAME EMMA SILENCE			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 213-46-2722		17 INFORMANT Masonic Home Records Address _____			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 Bronchopneumonia Acute DUE TO (b) 2 arteriosclerotic heart disease DUE TO (c) 3 Cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 1966 to Feb 2, 1967 , that (I) (we) last saw the deceased alive on Feb 2, 1967 , and that death occurred at 4:35 PM , from causes and on the date stated above							
22a SIGNATURE James H. Hamlen M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) JAMES H. HAMLEN		22d ADDRESS MASONIC HOME		22b. DATE SIGNED 12/1/67			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 2-4-67		23c NAME OF CEMETERY OR CREMATORY LODGE PARK CEM.		23d LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND	
24 FUNERAL DIRECTOR WM COOK		ADDRESS BROOKS TOWSON 1050 YORK RD TOWSON, MD 21204		25a REC'D BY REGISTRAR ECB		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01931

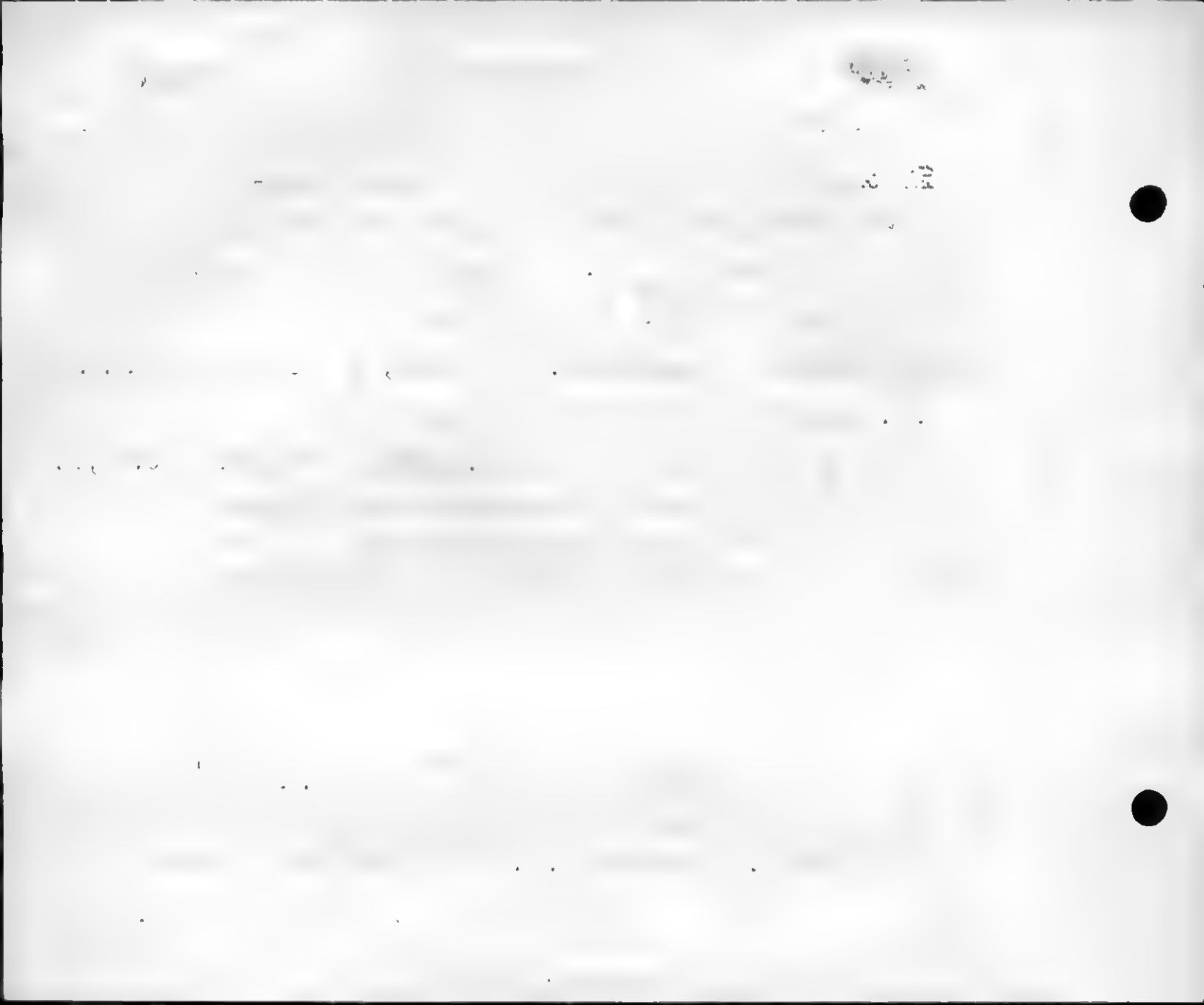
CERTIFICATE OF DEATH

01927

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN TB 68 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER - 21 d. STREET ADDRESS 1 BUTTERCUP LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First JOSEPH Middle A. Last RIDDICK		4. DATE OF DEATH Month FEBRUARY Day 16 Year 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/13/92
9 AGE (In years last birthday) 74		10 IF UNDER 1 YEAR Months 7 Days 16 Hours 16 Min 00	
10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN LINEMAN		10b. KIND OF BUSINESS OR INDUSTRY ELECTRIC CO.	
11. BIRTHPLACE (County & State or foreign country) AHOSKIE, NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME L. B. RIDDICK		14. MOTHER'S MAIDEN NAME URETTA DUNN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16 SOCIAL SECURITY NO 214 14 06 08	
17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RECURRENT RHABDOMYOSARCOMA OF RIGHT THIGH (b) ADENOCARCINOMA OF SIGMOID COLON (c) PNEUMONIA BILATERAL WITH METASTATIC NEOPLASM		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 8.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 12/10/66 , 19__, to 2/16/67 , 19__, that (we) lost saw the deceased alive on 2/16/67 , 19__, and that death occurred on 9:45AM from causes and on the date stated above.			
22a. SIGNATURE <i>George C. McElpatrick</i>		22b. DATE SIGNED 2/16/67	
22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/18/67	
23c. NAME OF CEMETERY OR CREMATORY Bohemian Nat. Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR 3331 Brehms Lane		25a. REC'D BY REGISTRAR SCHMUNEK FUNERAL HOME DATE FEB 20 1967	
		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01932

CERTIFICATE OF DEATH

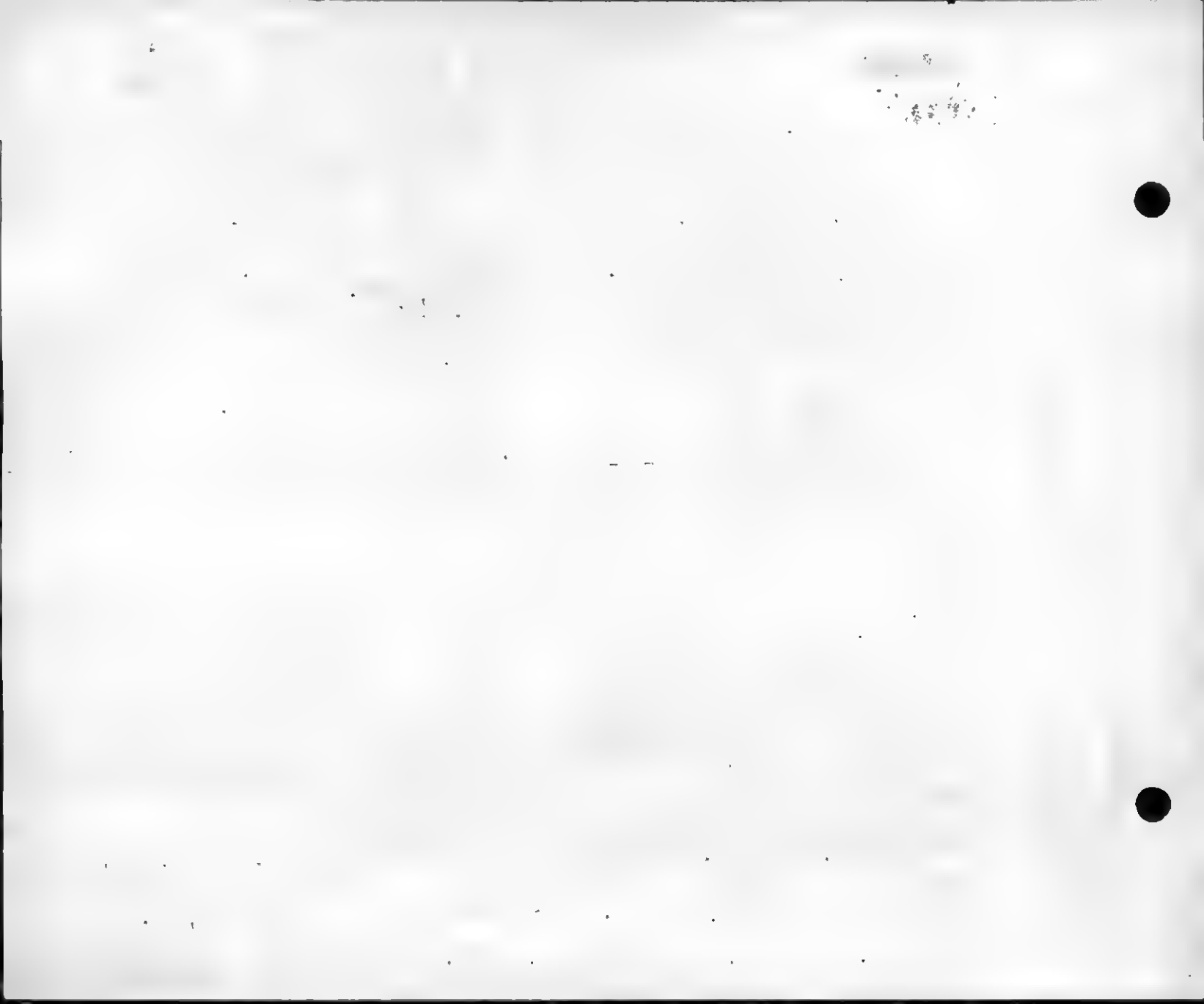
01928

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 18 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 723 Ramsay Street		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle (NMI) Last RIDDICK				4. DATE OF DEATH Month FEBRUARY Day 17 Year 19 67			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/1/98	
9. AGE (In years last birthday) yrs 69		10. IF UNDER 1 YEAR Months Days Hours Min 69		11. BIRTHPLACE (County & State, or foreign country) Providence, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (County & State, or foreign country) Providence, Virginia	
13. FATHER'S NAME Walter Riddick				14. MOTHER'S MAIDEN NAME Elizabeth Sandler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO 212-09-60-69		17. INFORMANT Clinical Records, VAH, Ft. Howard, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE PULMONARY EMBOLISM DUE TO (b) CHRONIC COR PULMONALE DUE TO (c) BRONCHIAL ASTHMA AND EMPHYSEMA							INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CONTR. B. TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that Dr. (this hospital) attended the deceased from Jan. 31 , 19 67 , to Feb. 17 , 19 67 , that (X) (we) last saw the deceased alive on Feb. 17 , 19 67 , and that death occurred at 7:40 PM from causes and on the date stated above.							
22a. SIGNATURE J. Fabara				22b. DATE SIGNED 2/18/67		22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M.D.	
22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND				22e. REGISTRAR'S SIGNATURE Charles A. Rice			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Charles A. Rice Fun. Home				25a. REC'D BY REGISTRAR DATE 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



01929

VR A15 (4)
20 M 1/66



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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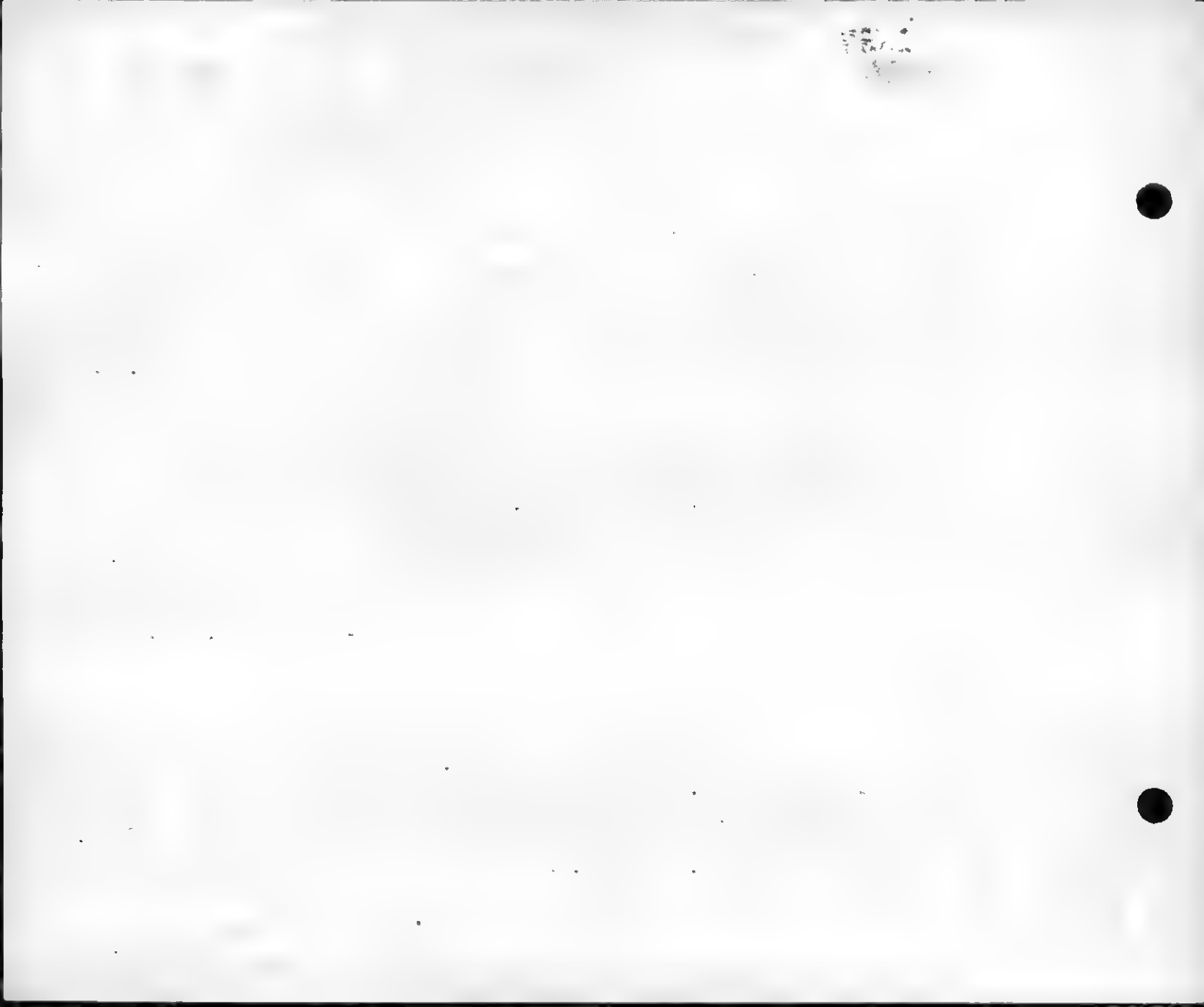
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01934

CERTIFICATE OF DEATH

01930

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____ ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 725 West Barre Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Robinson Last _____				4. DATE OF DEATH Month February Day 1 Year 19 67			
5. SEX female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1921	
9. AGE (In years last birthday) yrs. 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO				17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonay embolism, massive, acute 46607 DUE TO (b) Deep vein thrombosis, left leg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH acute 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Non-functioning left kidney - Cirrhosis (Laennec's) - Alcoholism, chr. Azotemia - Thrombosed internal hemorrhoids with bleeding							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (X) (this hospital) attended the deceased from Jan. 24, 1967 , to Feb. 1, 1967 , that (X) (we) lost the deceased alive on Feb. 1, 1967 , and that death occurred at 10:15 P. M, from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED 2-2-67		22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore	
24. FUNERAL DIRECTOR <i>Frederick A. Rice, 661 W. Barre St.</i>				25a. REC'D BY REGISTRAR DATE FEB 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01935

CERTIFICATE OF DEATH

01931

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1717 Kurtz Avenue</u>				d. STREET ADDRESS <u>1717 Kurtz Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>Roche</u>				4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 8, 1908</u>	9. AGE (in years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>G.L. Martin Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Iarnell Roche</u>				14. MOTHER'S MAIDEN NAME <u>Lula E. Hetrick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cg. of Bignin</u> <u>1930</u> DUE TO (b) <u>Chlorblastoma multiforme</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7, 1966</u> to <u>Feb 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 7, 1967</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>George T. Bulman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Towson, Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John Burns' Sons</u>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH
4 months



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01936

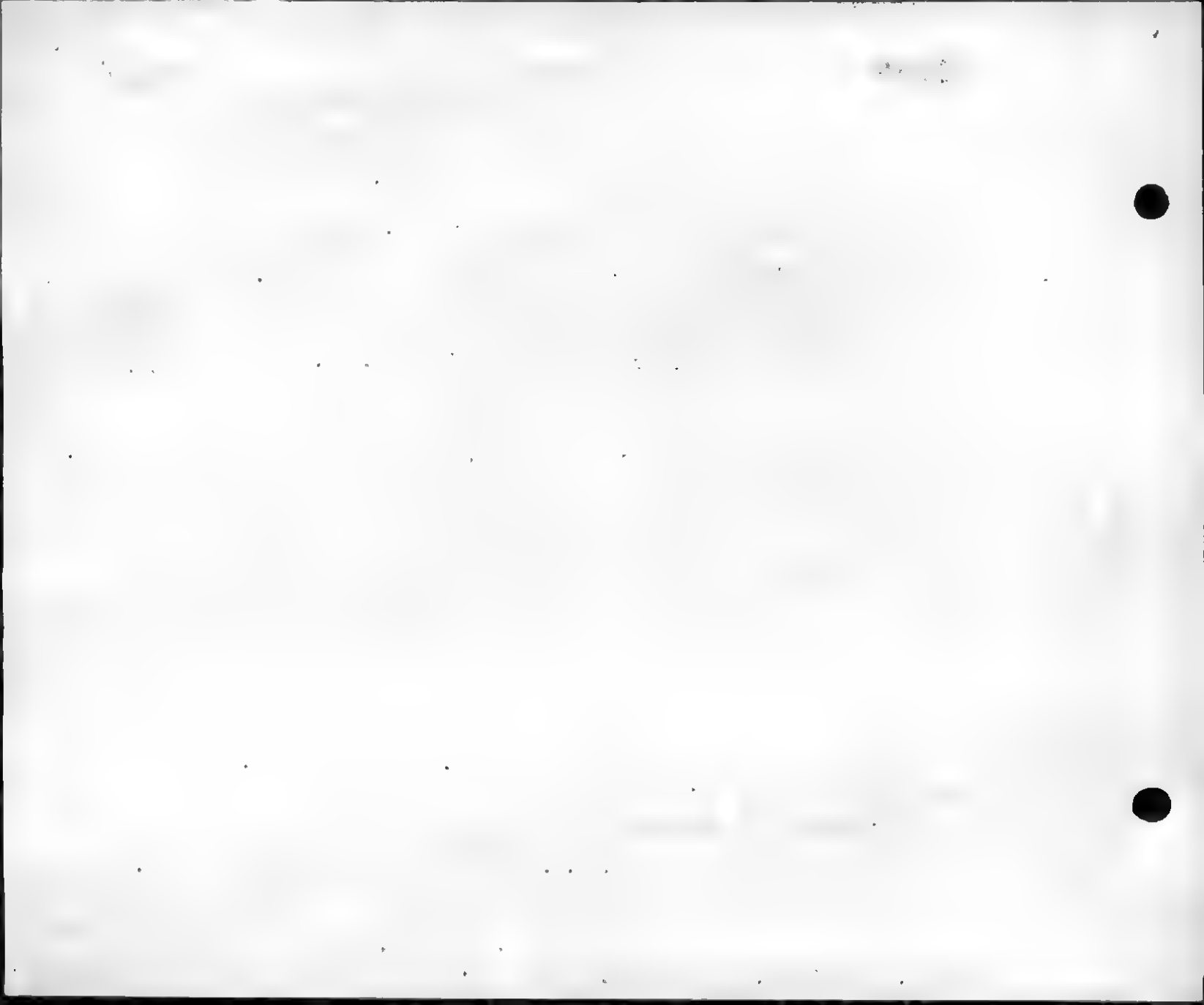
CERTIFICATE OF DEATH

01932

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY in 1b 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALBERT Middle DWYER Last ROCKS		4. DATE OF DEATH Feb. 22 Month Feb. Day 22 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/02
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Brewery Industry	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Rocks		14. MOTHER'S MAIDEN NAME Maggie Dwyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 218 03 84 99	
17. INFORMANT Clin. Rcds, VA Hospital, Ft Howard, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF LUNG 165X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (SQUAMOUS CELL CARCINOMA) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 9, 1967 , to Feb. 22, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 22, 1967 , and that death occurred at 8:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Carmelita A. Cendana		22b. DATE SIGNED 2-22-67	
22c. PHYSICIAN'S NAME (Type) CARMELITA A. CENDANA, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/27/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR JOHN A. MORAN, INC.		25. RECD BY REGISTRAR Baltimore, Md.	
25. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 24 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tarpon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

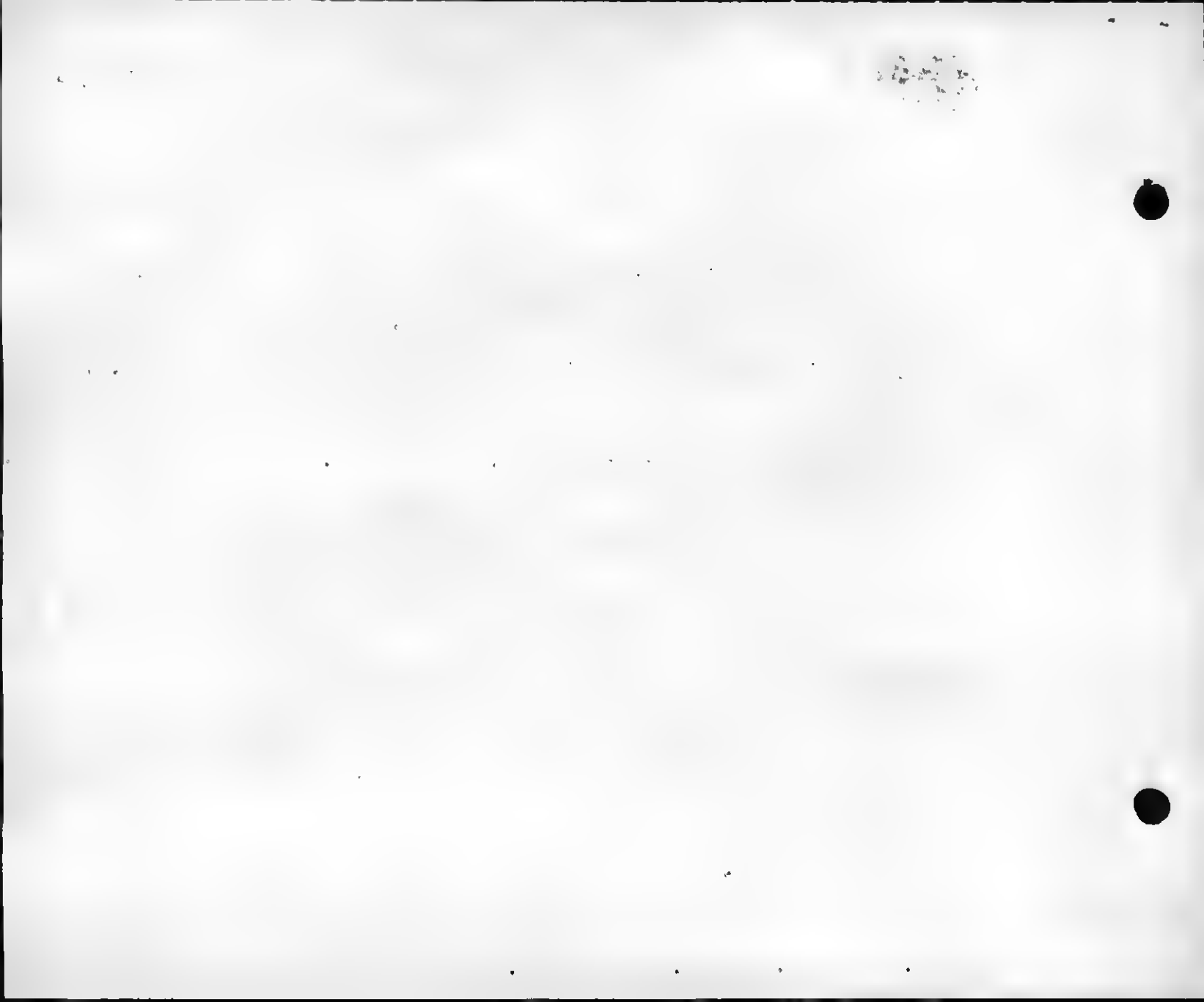
01937

CERTIFICATE OF DEATH

01933

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>908 Overbrook Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Francis Joseph Russell</u>		4 DATE OF DEATH <u>February 18, 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>March 14, 1893</u>
9 AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retail Clothing Salesman Clothing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Charles Russell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Powers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>216-07-8845</u>	
17. INFORMANT <u>Mrs. Catherine S. Russell</u>		Address <u>908 Overbrook Rd.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atherosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u> <u>12 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1953</u> to <u>18 Feb 1967</u> that (I) (we) last saw the deceased alive on <u>15 Feb 1967</u> and that death occurred at <u>9 P.</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Charles H. Reier</u>		22b. DATE SIGNED <u>20 Feb 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Reier</u>		22d. ADDRESS <u>6701 York Road</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/22/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>John A. Moran Inc. 3000 E. Baltimore St.</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

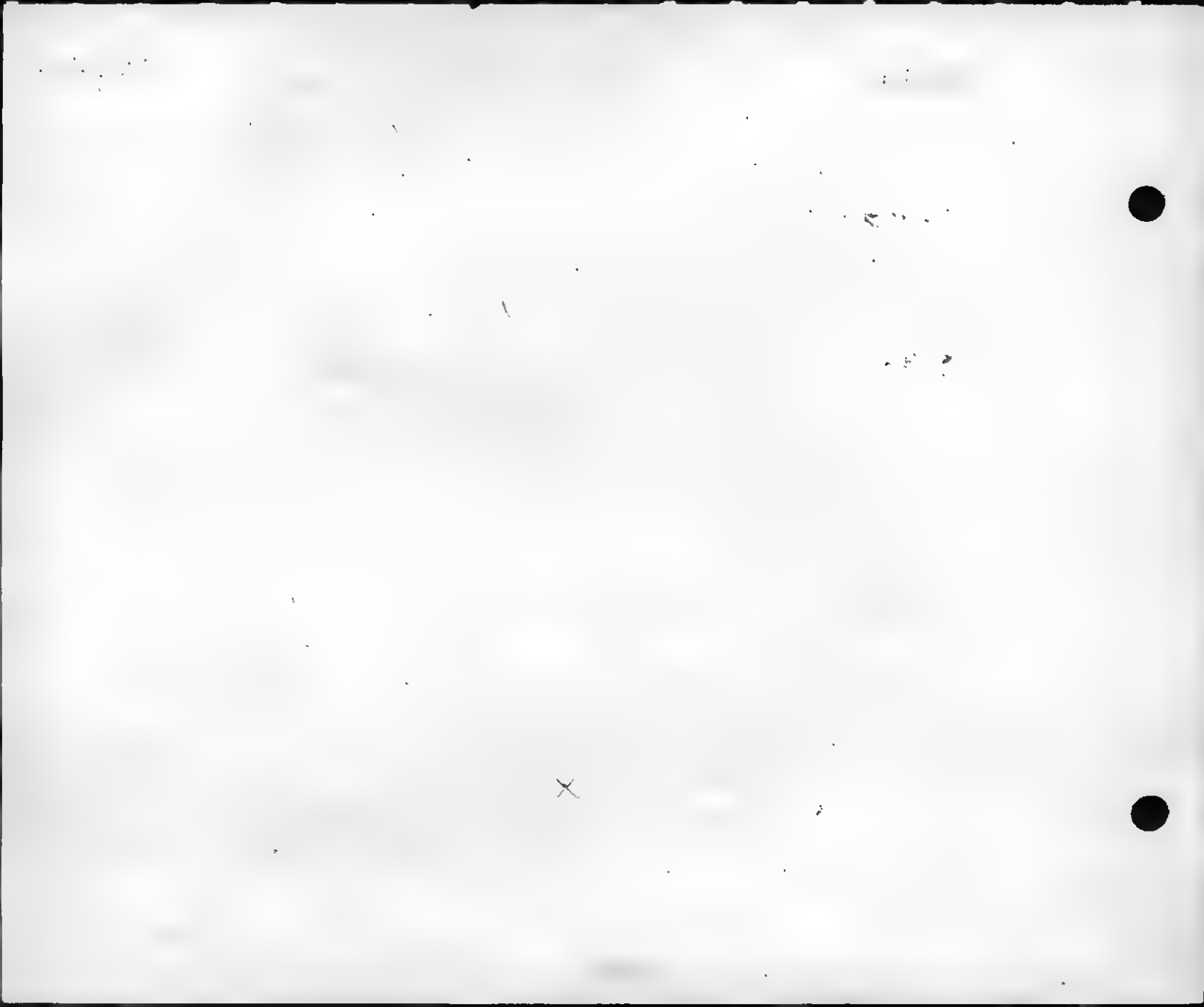
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01938

01934

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE - RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE - Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4 Cornett Ct</u>		d. STREET ADDRESS <u>4 Cornett Ct</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES William Samuels</u>		4. DATE OF DEATH <u>February 13 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 April 40</u>
9. AGE (In years last birthday) <u>26</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kitchens</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Samuels</u>		14. MOTHER'S MAIDEN NAME <u>Marian Hughes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1961-1962</u>		16. SOCIAL SECURITY NO. <u>220-26-5914</u>	
17. INFORMANT <u>Mrs. David Samuels</u>		Address <u>Balto., Md. 21212</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>TIGHTENING of leather slip knot about neck.</u>	
20c. TIME OF INJURY Month, Day, Year <u>1967 Feb 13 7:00 p.m.</u>		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John C. Hyle</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <u>2-13-67</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>2/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>	
23d. LOCATION (City, town or county) (State) <u>Mt. Carmel, Penn.</u>		23e. REC'D BY REGISTRAR <input checked="" type="checkbox"/> 23f. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>	
24. FUNERAL DIRECTOR <u>Farley Caranough</u>		ADDRESS <u>Catonsville, Md.</u>	



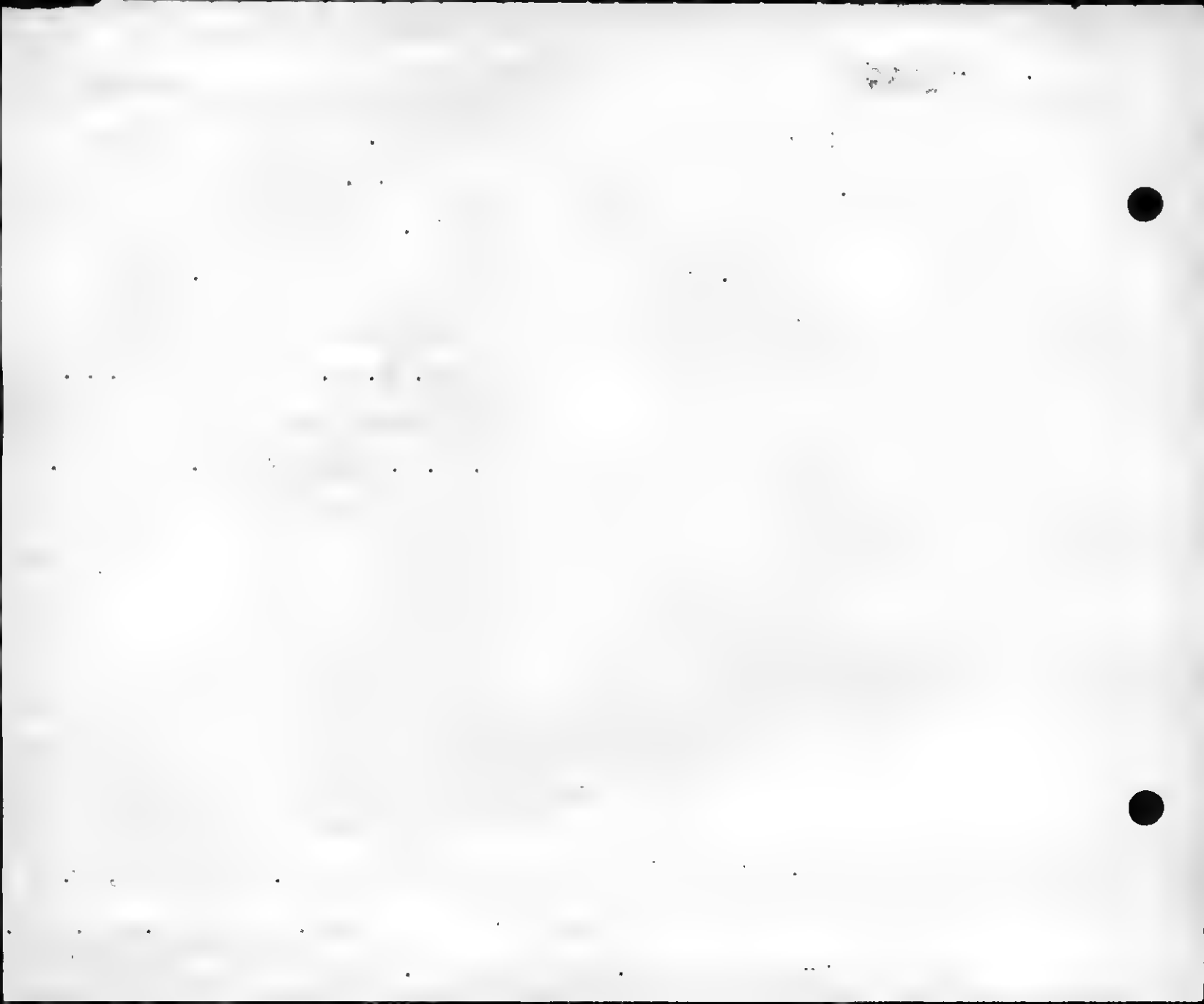
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
20 M 1/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01939		CERTIFICATE OF DEATH		01935	
1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balt. 21207</u>		c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balt. 21207</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>2615 N. Rolling Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>F. Estella Sauter</u>		4 DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>19 67</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/26/1875</u>	9 AGE (in years last birthday) <u>91</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Balt. Co. Md.</u>	
13. FATHER'S NAME <u>David Kalb</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Long</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>215-50-8848</u>		17 INFORMANT <u>Mrs. Wm. H. Leishear-2615 N. Rolling Rd.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Anterior Sclerosis</u> DUE TO <u> </u> (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>10 yrs</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> , to <u>2/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/24</u> , 19 <u>67</u> , and that death occurred at <u>10:4</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/1/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Mortin Ellin</u>		22d ADDRESS <u>8629 Liberty Rd. Randallstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	
23d. LOCATION (City or Town) <u>Balt. 2 Md.</u>		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u>		25a. REC'D BY REGISTRAR <u>6</u> 19 <u>67</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

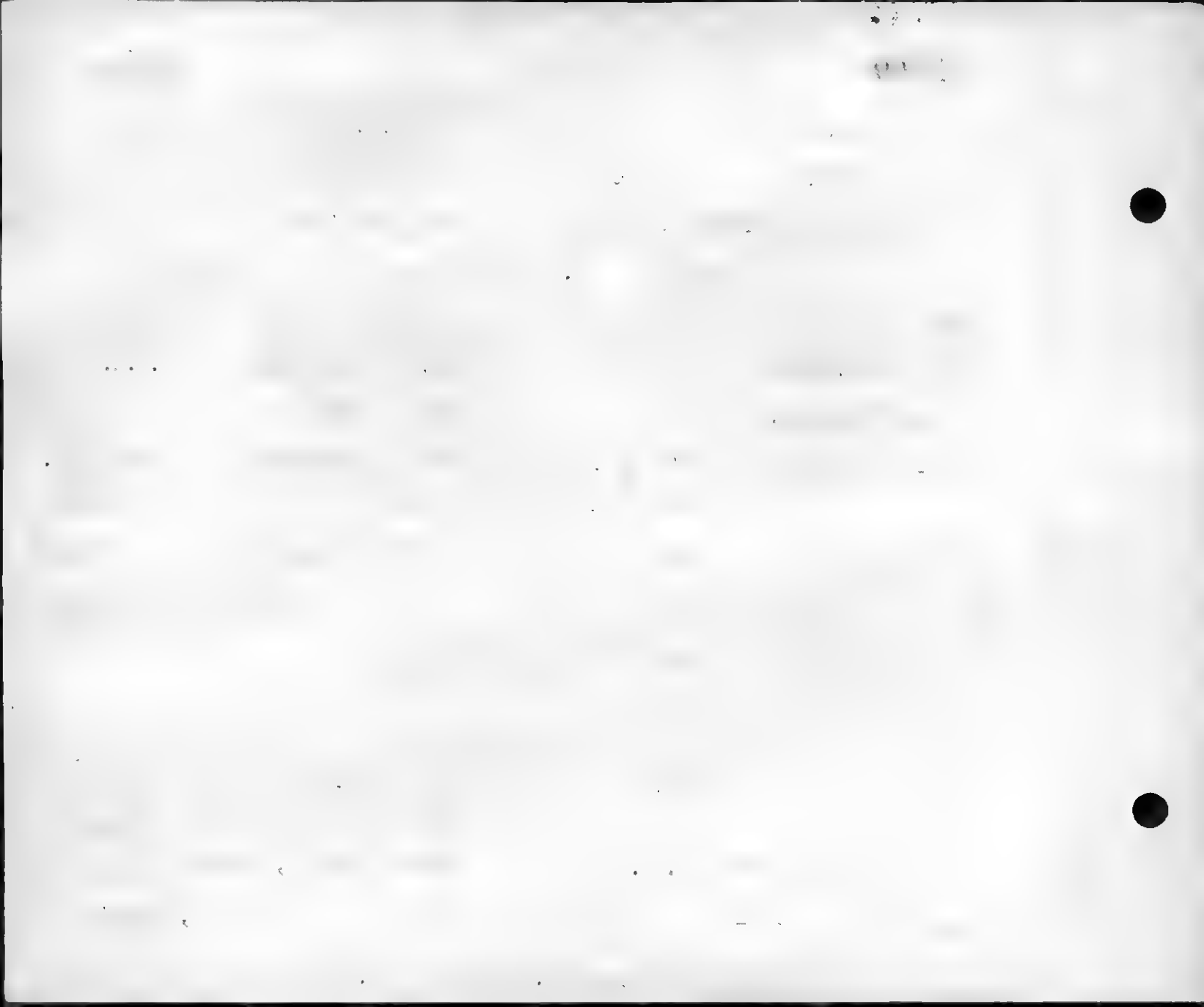
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G385 2/20/67 pc

01920

CERTIFICATE OF DEATH

01936

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY in b 43 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1316 LIGHT STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle M. Last SCEARCE		4 DATE OF DEATH Month FEBRUARY Day 15 Year 19 67	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/22 9. AGE (In years last birthday) 44 4/8 yrs IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEET METAL WORKER		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) DANVILLE, VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME BENJAMIN SCEARCE		14 MOTHER'S MAIDEN NAME EMMA BURNETT	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO 223 20 28 18	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, LEFT LOWER LOBE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HODGKIN'S DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH RECENT YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/3/67 , 19 67 , to 2/15/67 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/15/67 , 19 67 , and that death occurred at 10:25 AM from causes and on the date stated above.			
22a. SIGNATURE George Dudas		22b. DATE SIGNED 2/15/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-17-67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Wm S. Fleming		25a. REC'D BY REGISTRAR FLYNN & FLEMING FUNERAL HOME DATE FEB 17 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

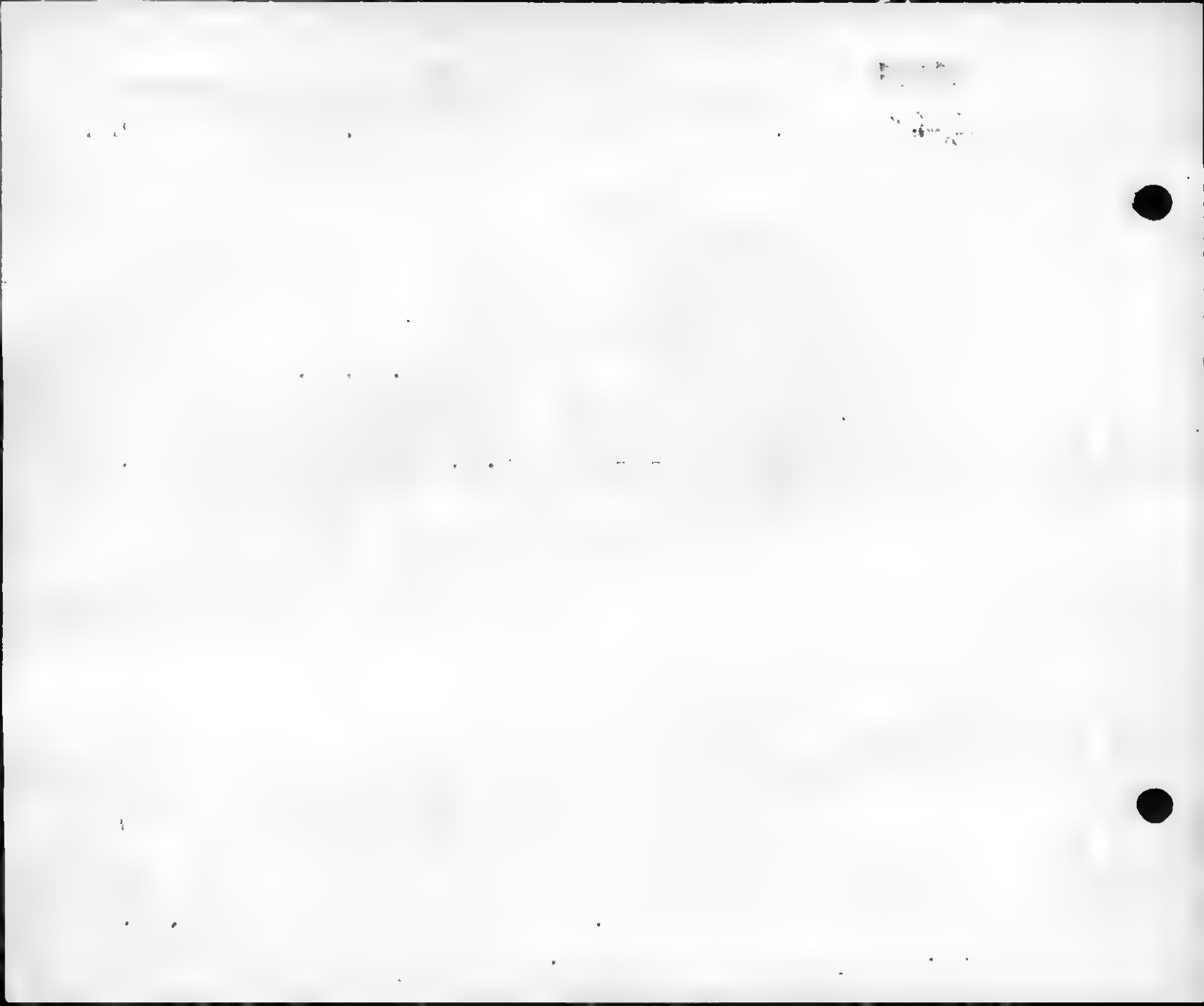
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01941

CERTIFICATE OF DEATH

01937

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<u>Reisterstown</u>		<u>13-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <u>CHAPEL HILL NURSING HOME</u>		d. STREET ADDRESS <u>Old Hanover Road</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Robert Schaeffer</u>		4 DATE OF DEATH Month <u>2</u> - Day <u>11</u> - Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>March 25, 1890</u>
9 AGE (In years and birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>Balto. Co. Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry C. Schaefer</u>		14. MOTHER'S MAIDEN NAME <u>Anna Walter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-7956</u>	
17. INFORMANT <u>Mrs. E. Grace Davis</u>		Address <u>Baltimore, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>33IX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CVA</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelonephritis + Pyelonephrosis</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-20-1967</u> , to <u>2-11-1967</u> , that (I) (we) last saw the deceased alive on <u>2-11-1967</u> , and that death occurred at <u>6:30</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Cesar Valle Cervero</u>		22b. DATE SIGNED <u>2-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u>		22d. ADDRESS <u>3624 Liberty Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Gilead Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co. Md.</u>	
24. FUNERAL DIRECTOR <u>J. F. Eline & Sons</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1967</u>	
ADDRESS <u>Reisterstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

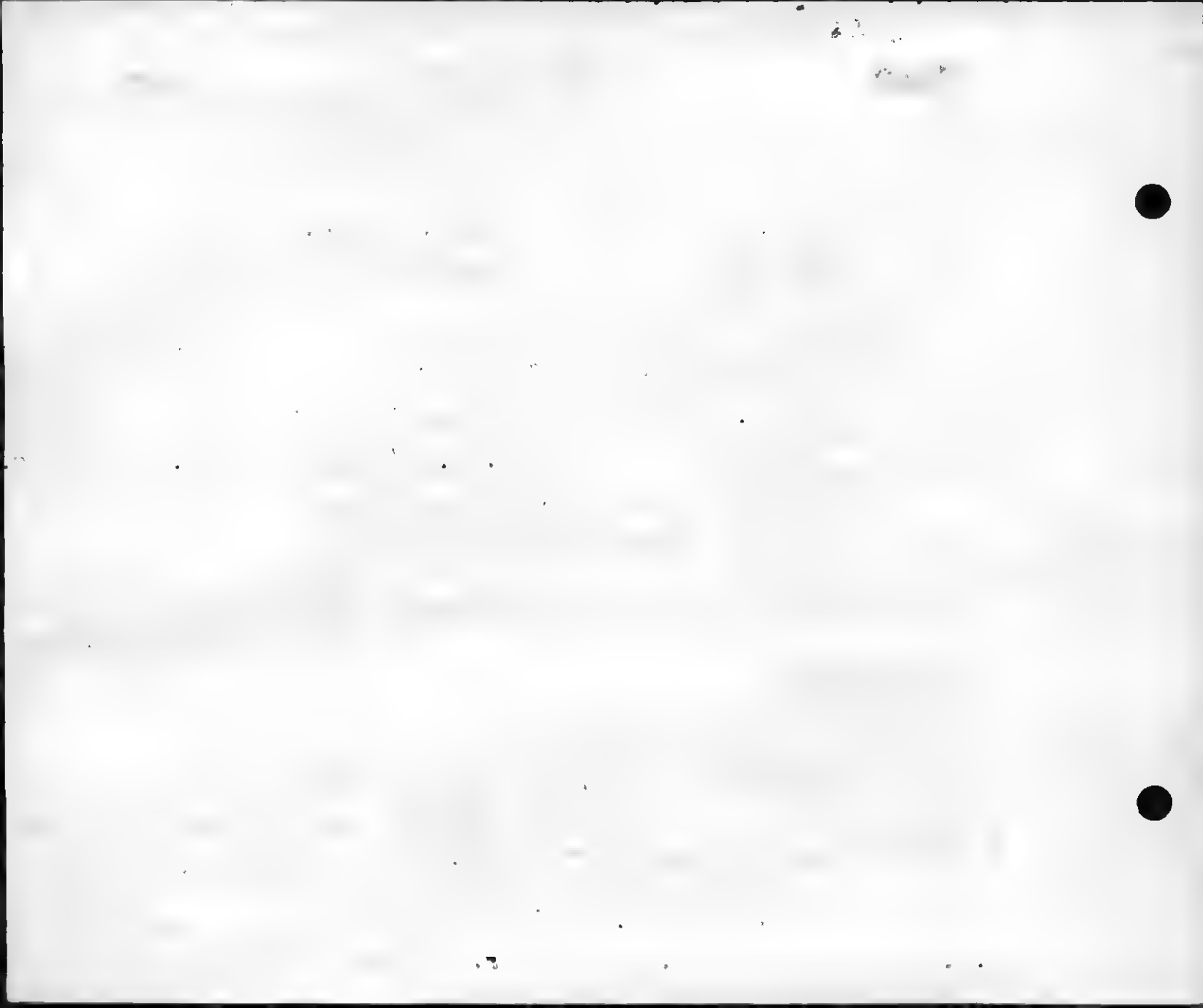
CERTIFICATE OF DEATH

01942

01938

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21210	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 911 W. Lake Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Rev. Carl F. SCHAPPERT		4. DATE OF DEATH Month Day Year February 24, 19 67	
5. SEX Male	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 16, 1886
9 AGE (In years last birthday) yrs 80		10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Religious	
10b KIND OF BUSINESS OR INDUSTRY PIEST ROMAN CATHOLIC		11 BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME GEORGE C. SCHAPPERT		14. MOTHER'S MAIDEN NAME ELIZABETH STINGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT REV. M. O'ROURKE		Address 1130 N. CALVERT ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that 1 (this hospital) attended the deceased from 2/10/ 19 67 , to 2/24/ 19 67 that we last saw the deceased alive on 2/24/ 19 67 , and that death occurred at 12:08 P. from causes and on the date stated above.			
22a. SIGNATURE Reynaldo Orjuella - Gomez		22b. DATE SIGNED February 24, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuella - Gomez		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/1/67	23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	23d. LOCATION (City or Town) (County) (State) WILKES-BARRE, PENN.
24. FUNERAL DIRECTOR N.W. MEARS & SON 305 N. CALVERT St.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 2 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

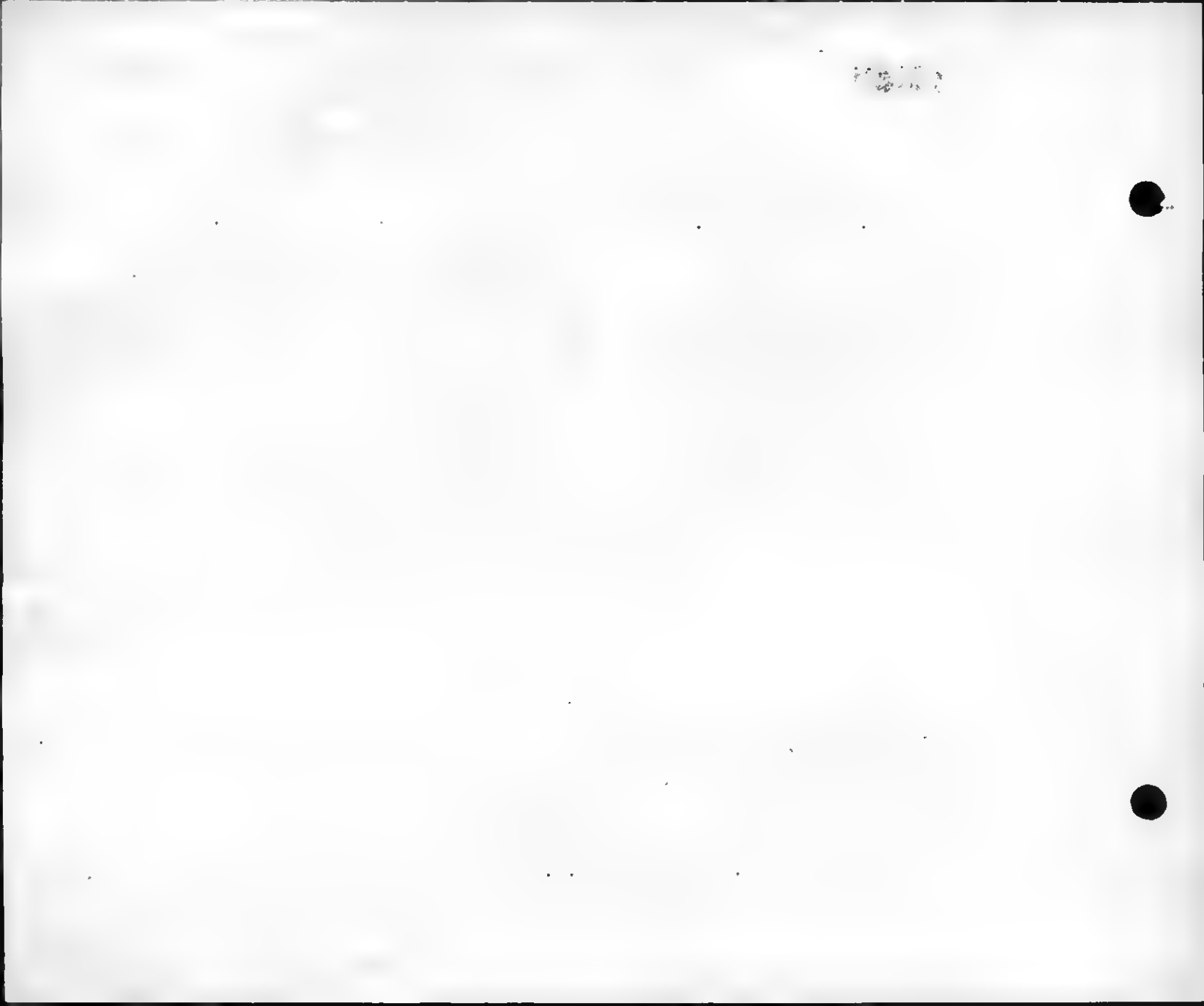
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01943

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01939

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland c. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EAST POINT		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EAST POINT	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 7727 E. Baltimore St.		d. STREET ADDRESS 7727 E. Baltimore St.	
3 NAME OF DECEASED (Type or print) First LAURA Middle SCHRADER Last SCHRADER		4 DATE OF DEATH Pronounced February 25, 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/5/59
9 AGE (in years last birthday) 7 yrs		10. F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) MD		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DONALD SCHRADER		14. MOTHER'S MAIDEN NAME PHYLLIS BARLOW	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO —	
17. INFORMANT ELEANOR HEMODA		Address 284-0246	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 1160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carbon monoxide DUE TO (c) Conflagration			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fire in row house	
20c. TIME OF INJURY Month, Day, Year Hour XX 11:40 p.m. 2-24 19 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office, bldg, etc.) Home	20f. (City or town) (County) (State) Baltimore Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) February 27, 1967	
22. DATE SIGNED			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/28/67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL	23d. LOCATION (City or Town) (County) (State) BALTO MD.
24. FUNERAL DIRECTOR J.G. CONNELLY SONS	ADDRESS 300 MACE		25a. REC'D BY REGISTRAR MAR 1 1967
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

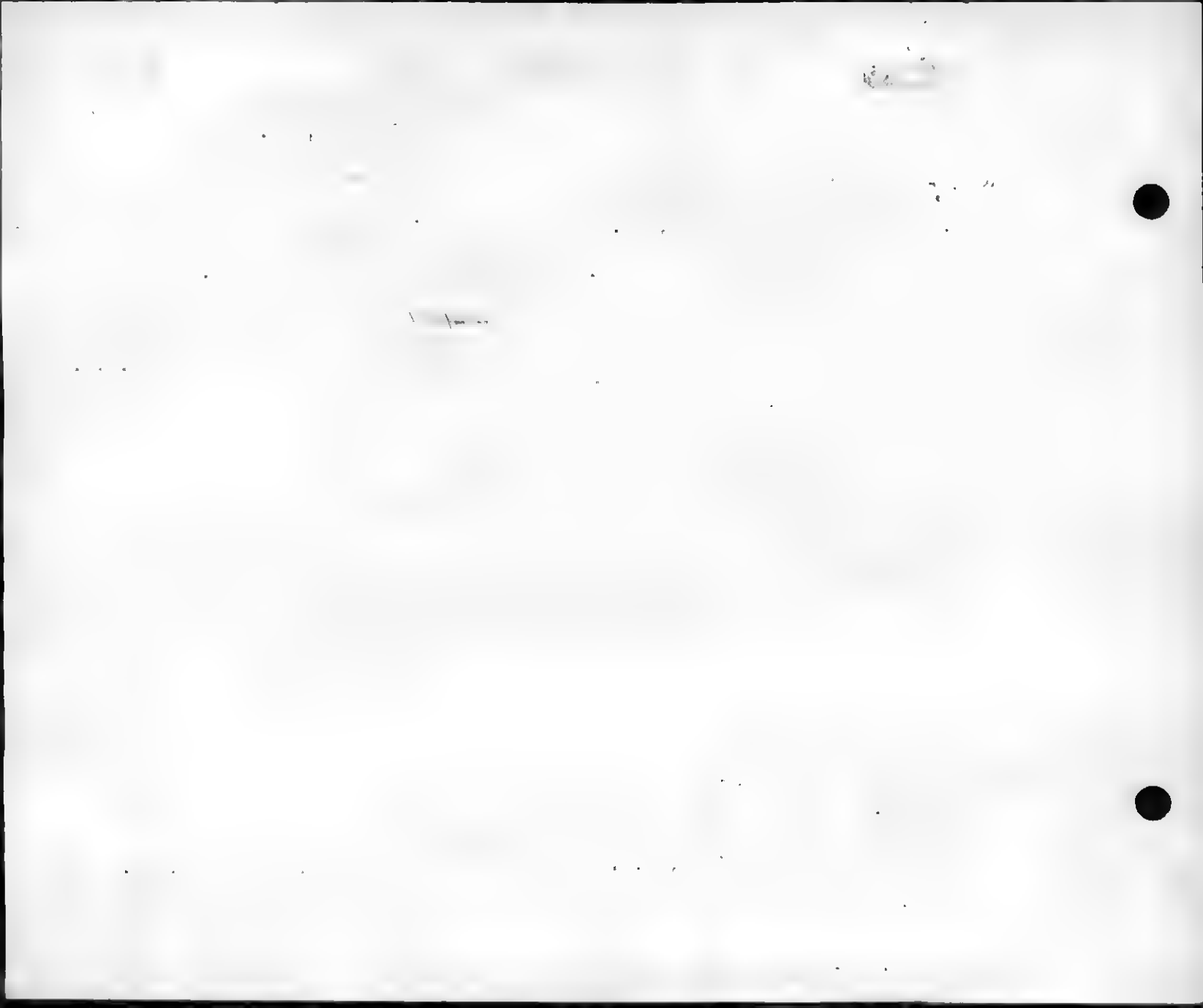
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01944

CERTIFICATE OF DEATH

01940

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Baltimore, Md. b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital, Towson, Md. 21204		d. STREET ADDRESS 3710 Raspe Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First ANNA Middle R. Last SCHUELER		4 DATE OF DEATH Month Feb. Day 19 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 5-7-1891
9 AGE (In years last birthday) 76 yrs.		10 IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Grief Co.	
11. BIRTHPLACE (County & State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Dudley		14. MOTHER'S MAIDEN NAME Victoria Ramsone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO _____	
17. INFORMANT Patient on admission		Address _____	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____
21. I certify that (I) (this hospital) attended the deceased from 2-9 , 19 67 , to 2-19 , 19 67 , that (I) (we) last saw the deceased alive on 2-19 , 19 67 , and that death occurred at 05:05 PM , from causes and on the date stated above.			
22a. SIGNATURE Regalado Dizon		22b. DATE SIGNED 2-19-67	
22c. PHYSICIAN'S NAME (Type) Regalado Dizon, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-22-67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR John C. Miller Inc. - 6415 Belair Road - 21206		25a. REC'D BY REGISTRAR DATE FEB 23 1967	
		25b. REGISTRAR'S SIGNATURE Harvey [Signature]	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Page 4 should be retained by the hospital or attending physician. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 62

<div style="display: flex; justify-content: space-between;"> <div> <p>1 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>01945</p> </div> <div> <p>MARYLAND CERTIFICATE OF DEATH</p> </div> <div> <p>01941</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. LENGTH OF STAY in 1b <u>33 yrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>101 Sherwood ave</u>				d. STREET ADDRESS <u>101 Sherwood ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry David Sharrer</u>				4. DATE OF DEATH Month Day Year <u>Feb 15 1967</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 12 1887</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done) during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>chips</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Taneytown Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>David H. Sharrer</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Heck</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>218-32-1255</u>		17. INFORMANT <u>Mrs Beulah Sharrer</u>		Address <u>101 Sherwood ave Pikesville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of right lung</u> DUE TO (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from... <u>1958 to Feb 15 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 15 1967</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Paul H Royse</u>				22b. DATE SIGNED <u>Feb 15, 1967</u>							
22c. PHYSICIAN'S NAME (Type) <u>PAUL H. ROYSE</u>				22d. ADDRESS <u>1403 Foley La. Pikesville, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) <u>Hanover, York Co. Pa.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Eline Funeral Home Hampstead, Md.</u>				25. REC'D BY REGISTRAR <u>FEB 20 1967</u>				25b. REGISTRAR'S SIGNATURE <u>M. Jones</u>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01946

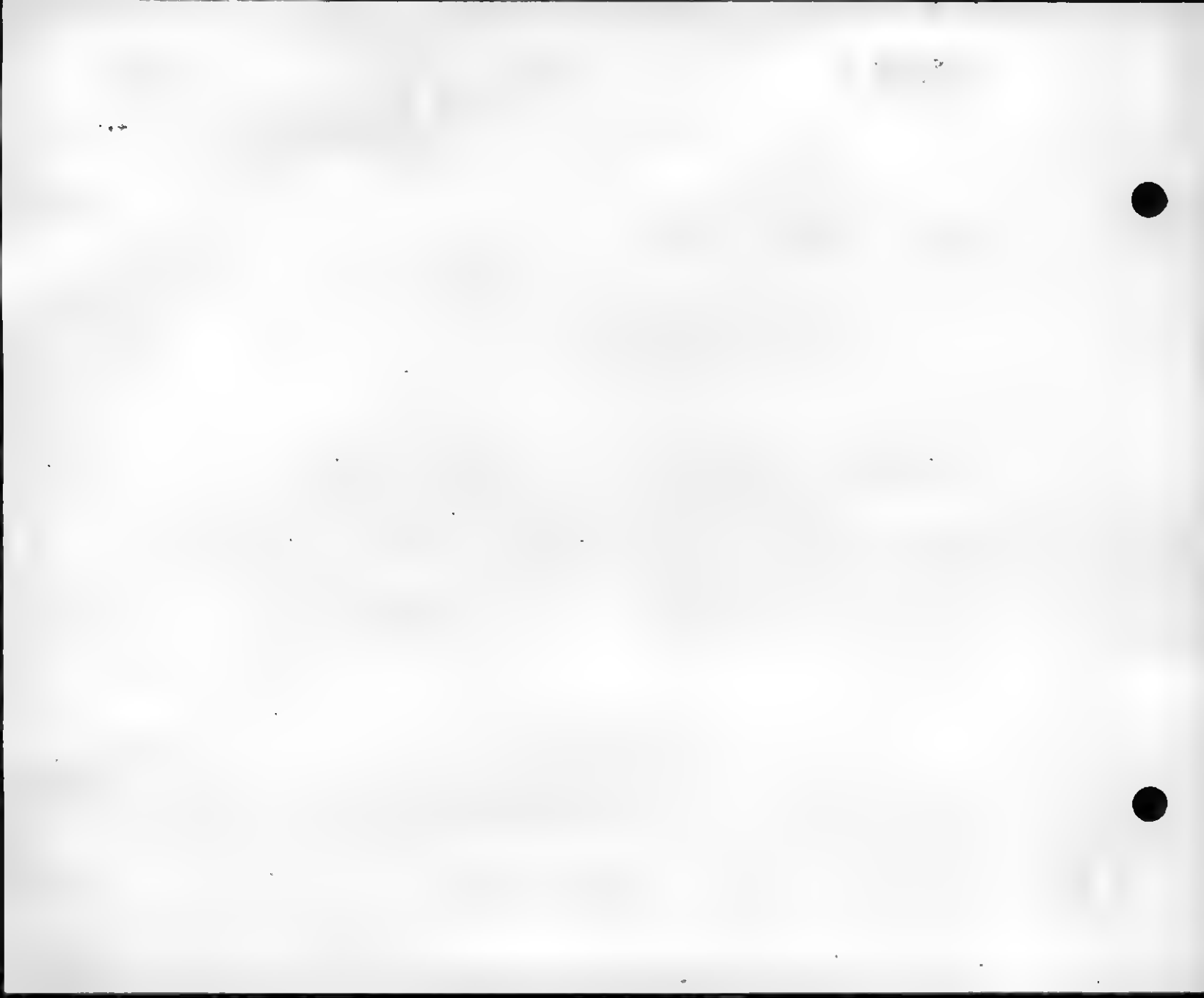
CERTIFICATE OF DEATH

01942

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> ✓			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forest Haven Nursing Home</u>				d. STREET ADDRESS <u>Box 8</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>H.</u> Last <u>Simmerman</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 14, 1872</u>	9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Salem, N.J.</u>		12. CIT. ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Dikes</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mabel Monrey 744 Sommers Road, Phila. Pa.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART-SCIENTIFIC CHAMBER-UNSPECIFIED</u> <u>40+1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>MISFEAR, & GENERAL UNUSUAL</u> DUE TO (c) <u>PULMONARY EDEMA - PREHEMORRHOIC</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> , 19 <u>66</u> , to <u>2/23</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>2/22</u> , 19 <u>67</u> , and that death occurred at <u>2 PM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>John H. Spivey M.D.</u>				22b. DATE SIGNED <u>2/23/67</u>		22c. PHYSICIAN'S NAME (Type) <u>John H. Spivey M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/26/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fernwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Reversford Montgomery Pa.</u>	
24. FUNERAL DIRECTOR <u>Easton Funeral Home Catonsville, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01947

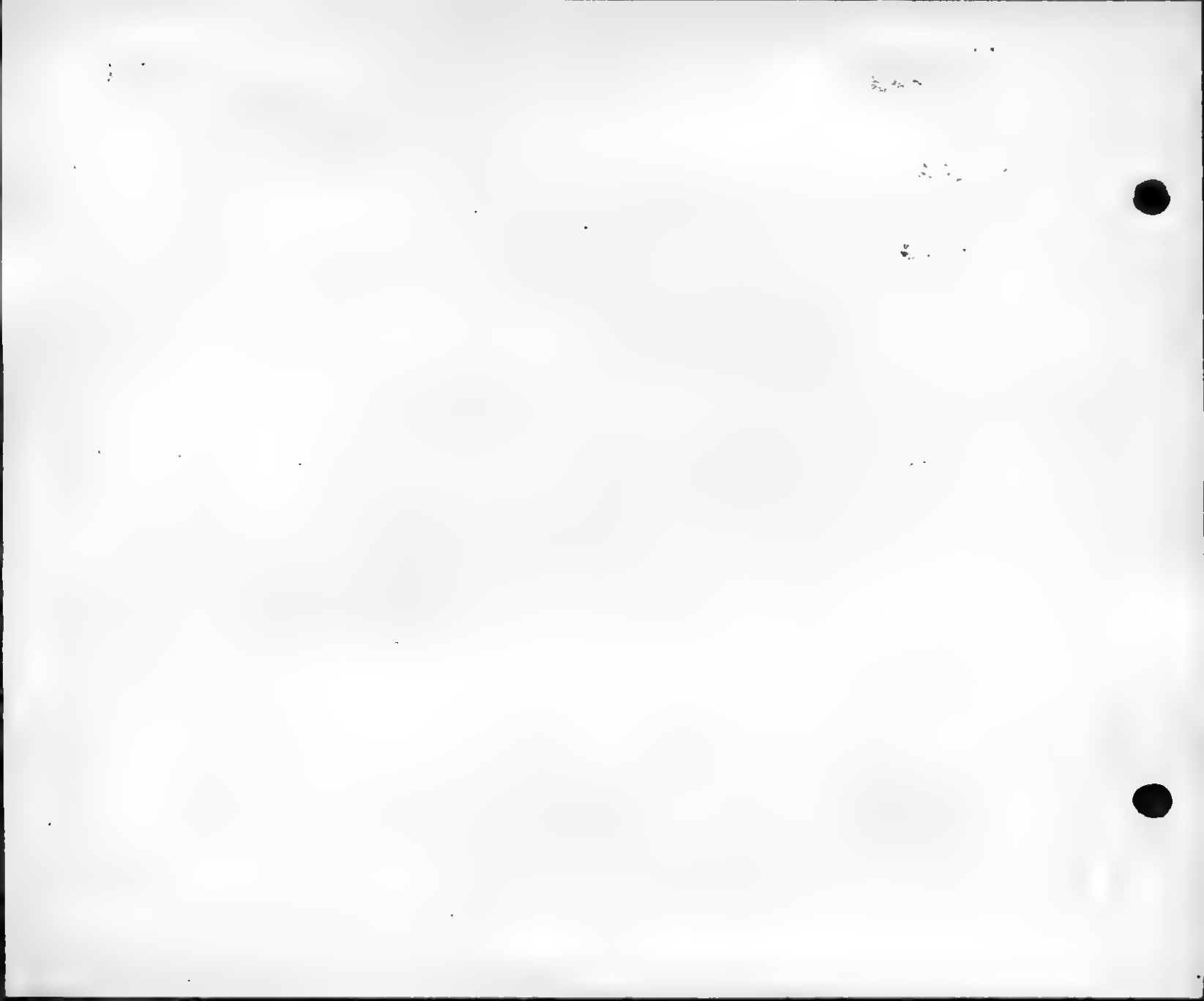
CERTIFICATE OF DEATH

01943

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balti</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 21207 Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>3415 Mayfair Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>E.</u> Last <u>Skinner</u>		4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. CO. OR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22/90</u>
9. AGE (in years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> Hours <u>16</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Miss</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Skinner</u>		14. MOTHER'S MAIDEN NAME <u>Marguerite ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>175 01-9610A</u>	
17. INFORMANT <u>Theodore L. Skinner</u>		Address <u>3415 Mayfair Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiovascular Failure</u> (b) <u>Or Pneumonia</u> (c) <u>Emphysema + Bronchial asthma</u>			
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia, & of Lung (apertia)</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-2</u> , 19 <u>67</u> , to <u>2-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> , 19 <u>67</u> , and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Angelita Topano M.D.</u>		22b. DATE SIGNED <u>2-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANGELITA TOPANO M.D.</u>		22d. ADDRESS <u>BCH</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-7-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Abington Hills</u>	23d. LOCATION (City or town) (County) (State) <u>Chinchilla, Pa.</u>
24. FUNERAL DIRECTOR <u>Long Bros 8728 Liberty Rd. Randallstown</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 7 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

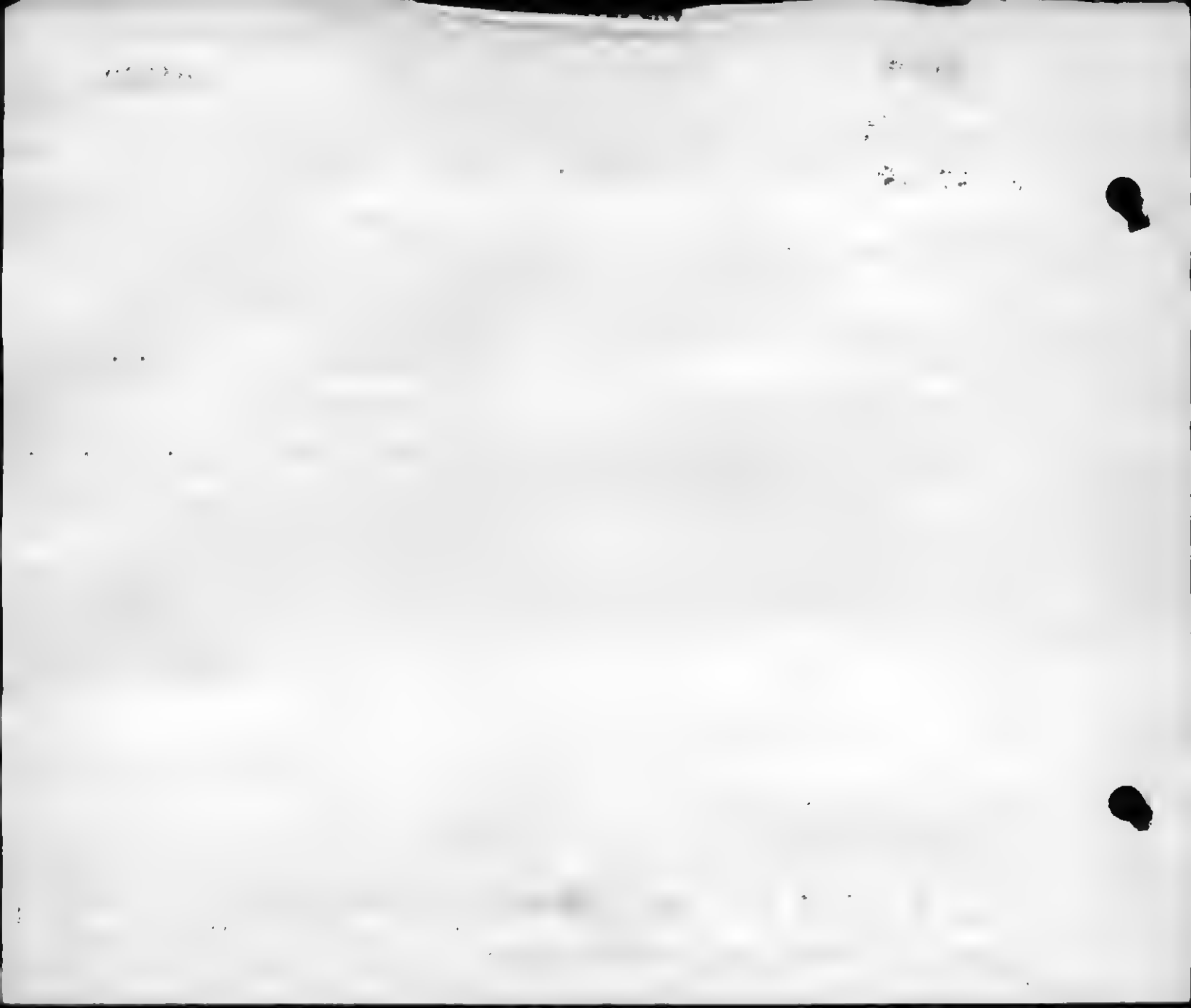


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 1 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01948 CERTIFICATE OF DEATH 01944

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; for use on before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Relay		c. LENGTH OF STAY IN 1b two yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) XXXXXX Relay	
3. NAME OF DECEASED (Type or print) Sister Mary Cyrilla Smith		d. STREET ADDRESS 701 Gun Road	
6. SEX F		7. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 13, 1893	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Topeka, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Smith		14. MOTHER'S MAIDEN NAME Sarah Hamilton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 220560134	
17. INFORMANT Sr. M. Magdalen		Address 701 Gun Rd. Balto. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) Chronic Renal Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).		INTERVAL BETWEEN ONSET AND DEATH One year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1967 to Feb 5 1967 that (I) (we) last saw the deceased alive on Jan 4 1967, and that death occurred at 11:29 AM , from the causes and on the date stated above.		22a. SIGNATURE Emidio A. Bianco M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Emidio A. Bianco		22d. ADDRESS 3350 Wilkens Ave 21229	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 9/67	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem		23d. LOCATION (City, town or county) (State) 4300 Old Frederick Road	
24. FUNERAL DIRECTOR'S SIGNATURE Zora W. Elickson		25a. REC'D BY REGISTRAR Feb 20 1967	
ADDRESS 1129 N. Caroline St		25b. REGISTRAR'S SIGNATURE Wm J. J.	



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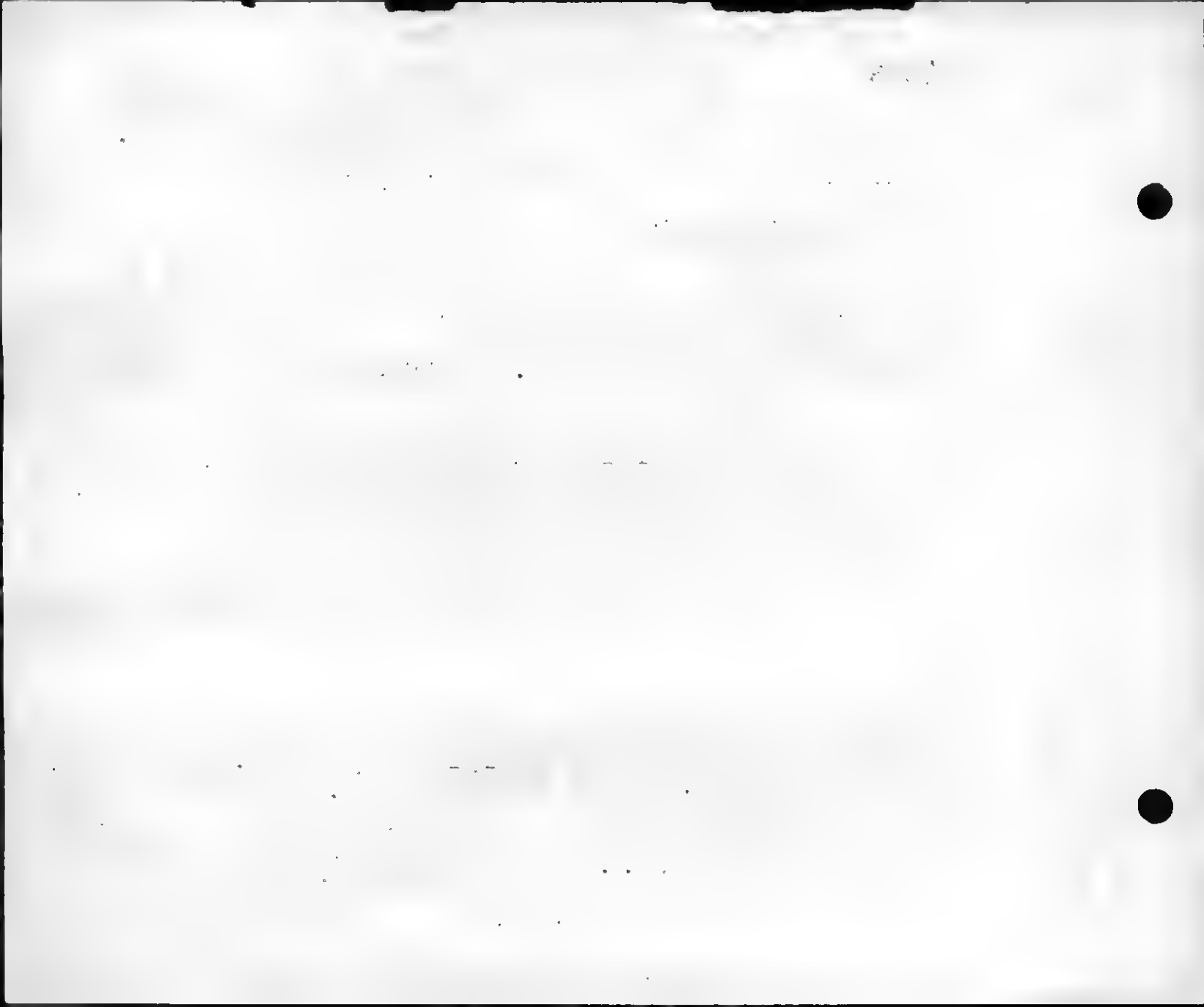
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01949

CERTIFICATE OF DEATH

01945

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 38yr4mth27dy	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital 1		d. STREET ADDRESS Almshouse	
3. NAME OF DECEASED (Type or print) First Mary Middle Smo Last nick		4. DATE OF DEATH Month February Day 15 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1891
9 AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Galicia, Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME None		14. MOTHER'S MAIDEN NAME None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 219-54-3434	
17. INFORMANT Spring Grove State Hospital: Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral pneumonia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from 9-18-28 , 18 to Feb. 15, 1967 , that (I) (we) last saw the deceased alive on Feb. 15, 1967 , and that death occurred at 9:55 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Evelio Felipe</i>		22b. DATE SIGNED 2-15-67	
22c. PHYSICIAN'S NAME (Type) Evelio Felipe, M.D.		22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2-20-67	New Cathedral	Old French Road/Balto Md
24. FUNERAL DIRECTOR Krause Funeral Home 1216 S Charles St		25a. REC'D BY REGISTRAR DATE FEB 23 1967	
25b. REGISTRAR'S SIGNATURE			



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1

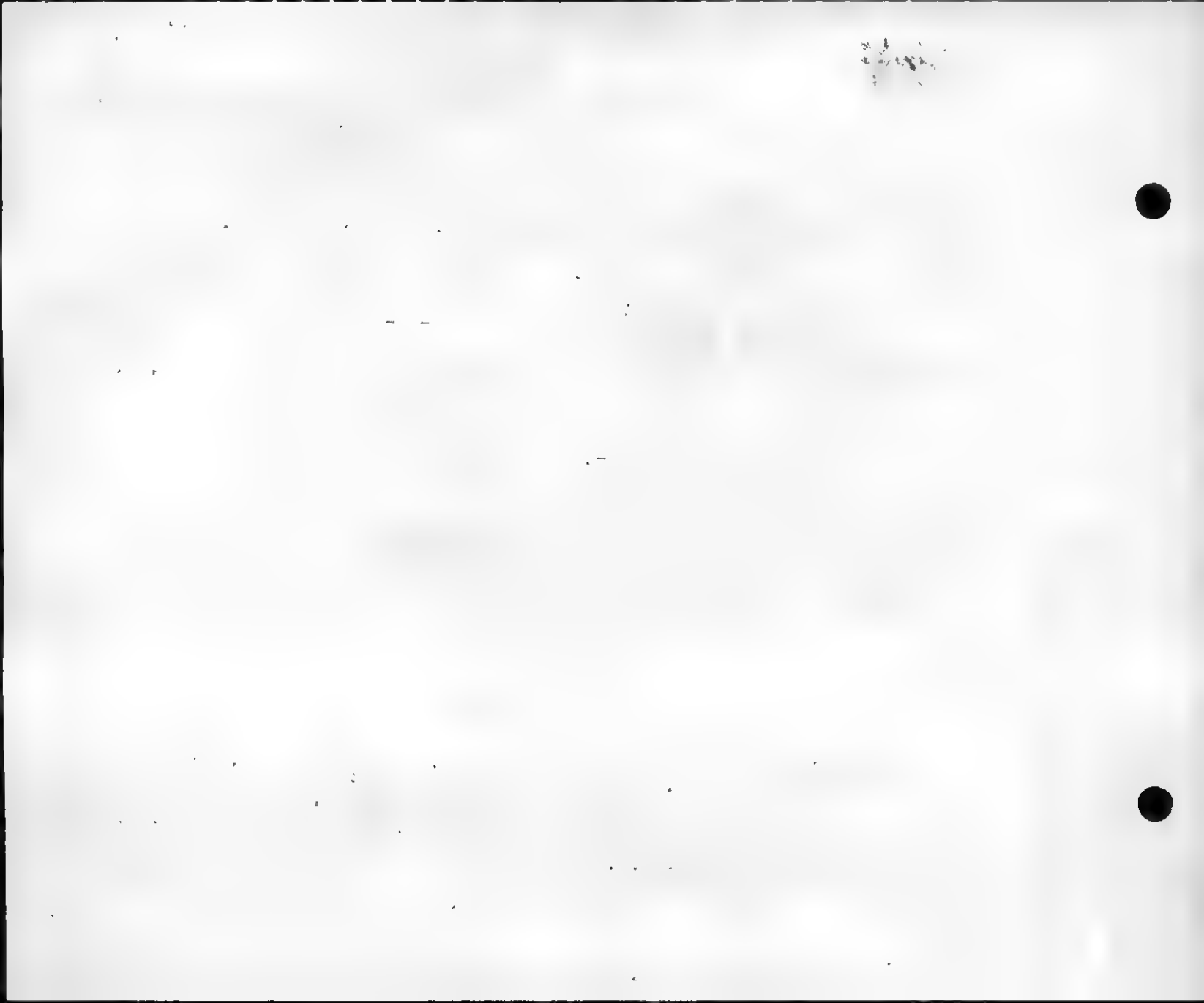
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01950

CERTIFICATE OF DEATH

01946

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 2yrlmth3dys			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 5926 Charles Street 2511 West Lombard St.	
3 NAME OF DECEASED (Type or print) First John Middle H. Last Smyth		4 DATE OF DEATH Month February Day 10 Year 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 1884 9-14-84
9 AGE (In years past birthday) yrs 82		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U. S. A.			
13 FATHER'S NAME John Smyth		14 MOTHER'S MAIDEN NAME Dorothy Sprunger	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 218-10-3163	
17 INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized and severe			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Jan. 7, 1965 to Feb. 10, 1967 , that (X) (we) last saw the deceased alive on Feb. 10, 1967 , and that death occurred at 12:25 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Stella Wachler</i>		22b. DATE SIGNED 2-10-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachler, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2-13-1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) 3801 Frederick Ave, Balto.Md.
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229		25a. REC'D BY REGISTRAR DATE FEB 14 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01951

CERTIFICATE OF DEATH

01947

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>4 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENN DALE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>ROUTE #1-BOX #139</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AGNES REBECCA SNOWDEN</u>				4. DATE OF DEATH Month Day Year <u>2 14 1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-16-86</u>	
9. AGE (In years last birthday) <u>80</u> yrs		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE'S AID</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOSPITAL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>LEONARD HERBERT</u>			
14. MOTHER'S MAIDEN NAME <u>THEREIA NEAL</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO <u>720-03-1732</u>				17. INFORMANT Address <u>EUGENE SNOWDEN-SAME AS PT'S</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4/21</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>YEARS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from <u>12-27, 1963</u> to <u>2-14, 1967</u> , that (A) (we) last saw the deceased alive on <u>2-14</u> 19 <u>67</u> , and that death occurred at <u>2:24</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>Rolando Viera</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>2-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO VIERA</u>				22d. ADDRESS <u>SPRING GROVE ST. HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/18/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY FAMILY CEMETERY, Mitchellville, Va</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Alex S. Pope, Jr.</u>				414-15th St S.E. <u>W. 2nd St. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 16 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

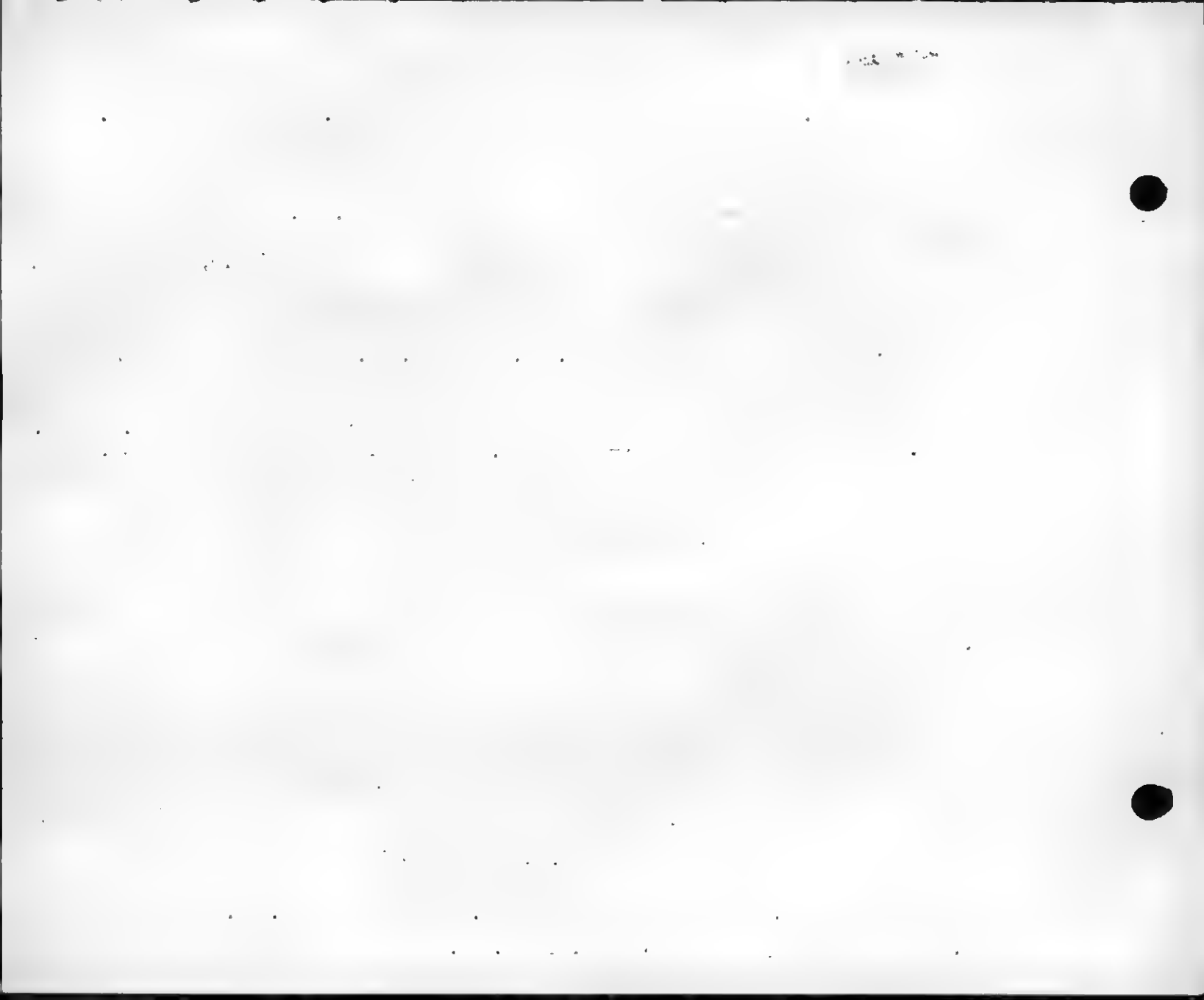
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01952 CERTIFICATE OF DEATH 01948

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>7 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Summit Nursing Home</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgemoore</u>			
				d. STREET ADDRESS <u>Chesapeake Ave. Rt. 10 Box 19X</u>			
3. NAME OF DECEASED (Type or print) <u>Louis</u> <u>First</u> <u>Middle</u> <u>Sohn</u> <u>Last</u>				4. DATE OF DEATH <u>Feb. 8,</u> <u>19 67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1887</u>	
9. AGE (in years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothing Cutter</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Sohn</u>				14. MOTHER'S MAIDEN NAME <u>Anna Raab</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>215-01-8561</u>		17. INFORMANT <u>Mr. William L. Sohn</u>		Address <u>Box 19 X Balto. 19, Md.</u> <u>Chesapeake Ave, Rt. 10</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vasc. Dis</u> <u>443X</u> DUE TO <u>Wrenuci</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-6-67</u> to <u>2-8-67</u> , that (I) (we) last saw the deceased alive on <u>2-6-67</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>I. EARL PASS</u>				22b. DATE SIGNED <u>2-8-67</u>		22c. PHYSICIAN'S NAME (Type) <u>I. EARL PASS</u>	
22d. ADDRESS <u>4001 Wilkins Ave</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>G. Truman Schwab</u>				25a. REC'D BY REGISTRAR <u>10 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J...</u>	



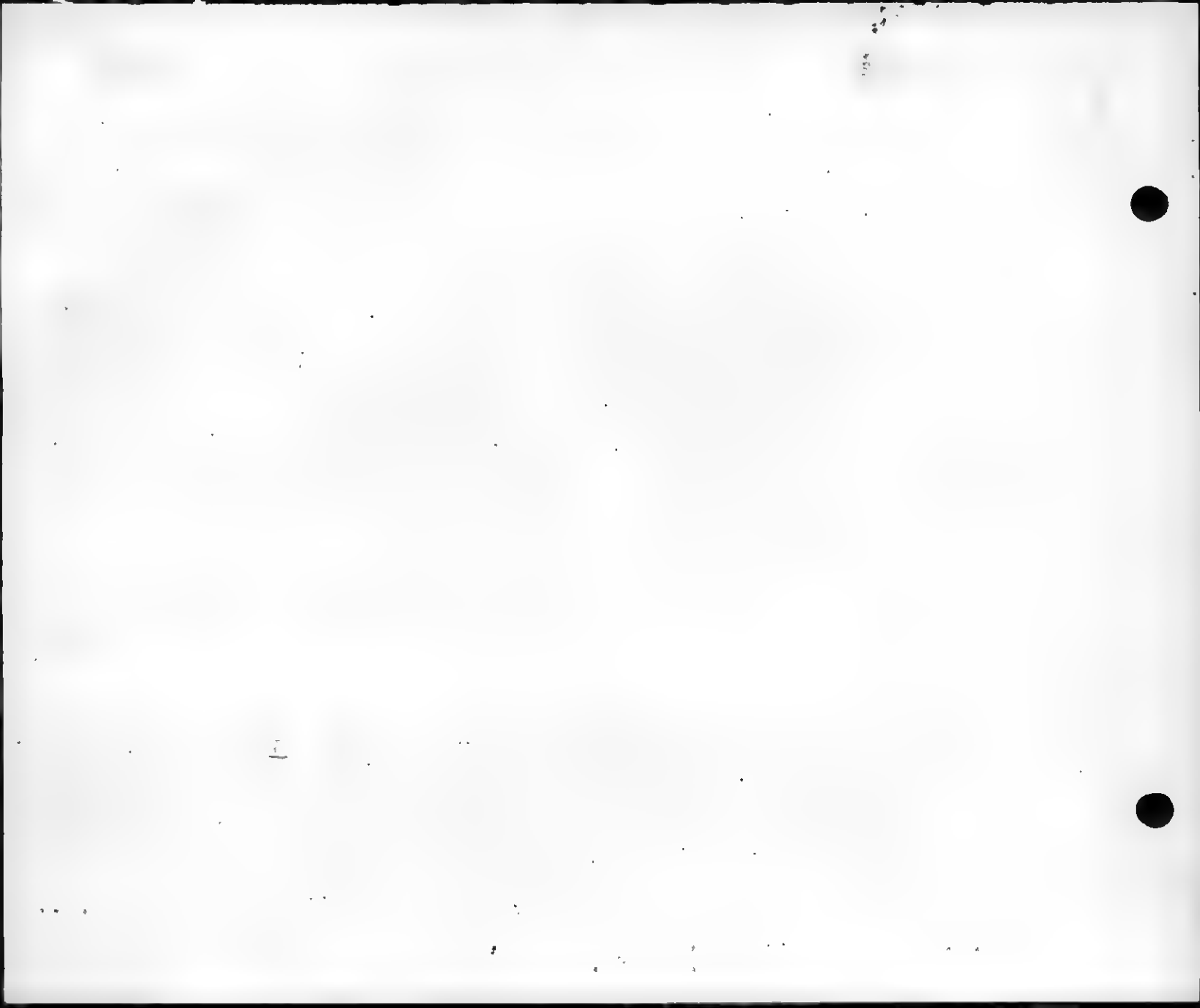
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ZDM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01953					01949				
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>NORTH CAROLINA</u> b. COUNTY <u>ASHEVILLE</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ASHEVILLE</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTO MEDICAL CENTER</u>					d. STREET ADDRESS <u>5 CALADONIA ROAD</u> <u>6701 N CHARLES ST.</u>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSAN WALKER SPALDING</u>					4. DATE OF DEATH Month Day Year <u>2-15-1967</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-18-76</u>		9. AGE (In years last birthday) <u>90</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ROMNEY W. VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>HOLDRIDGE CHIDESTER</u>					14. MOTHER'S MAIDEN NAME <u>HANNA SUSAN WALKER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>213-05-4920</u>				
17. INFORMANT <u>RICHARD N. WILLS, McDONOUGH, Md.</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> , 19 <u>67</u> to <u>2-15</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2-15</u> , 19 <u>67</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Manuel V. Gatchalian</u>					22b. DATE SIGNED <u>2-15-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>MANUEL V. GATCHALIAN</u>					22d. ADDRESS <u>6701 N CHARLES ST</u>				
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/16/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville, Balto. Co. Md</u>		
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>					25a. REC'D BY REGISTRAR <u>FEB 16 1967</u>				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

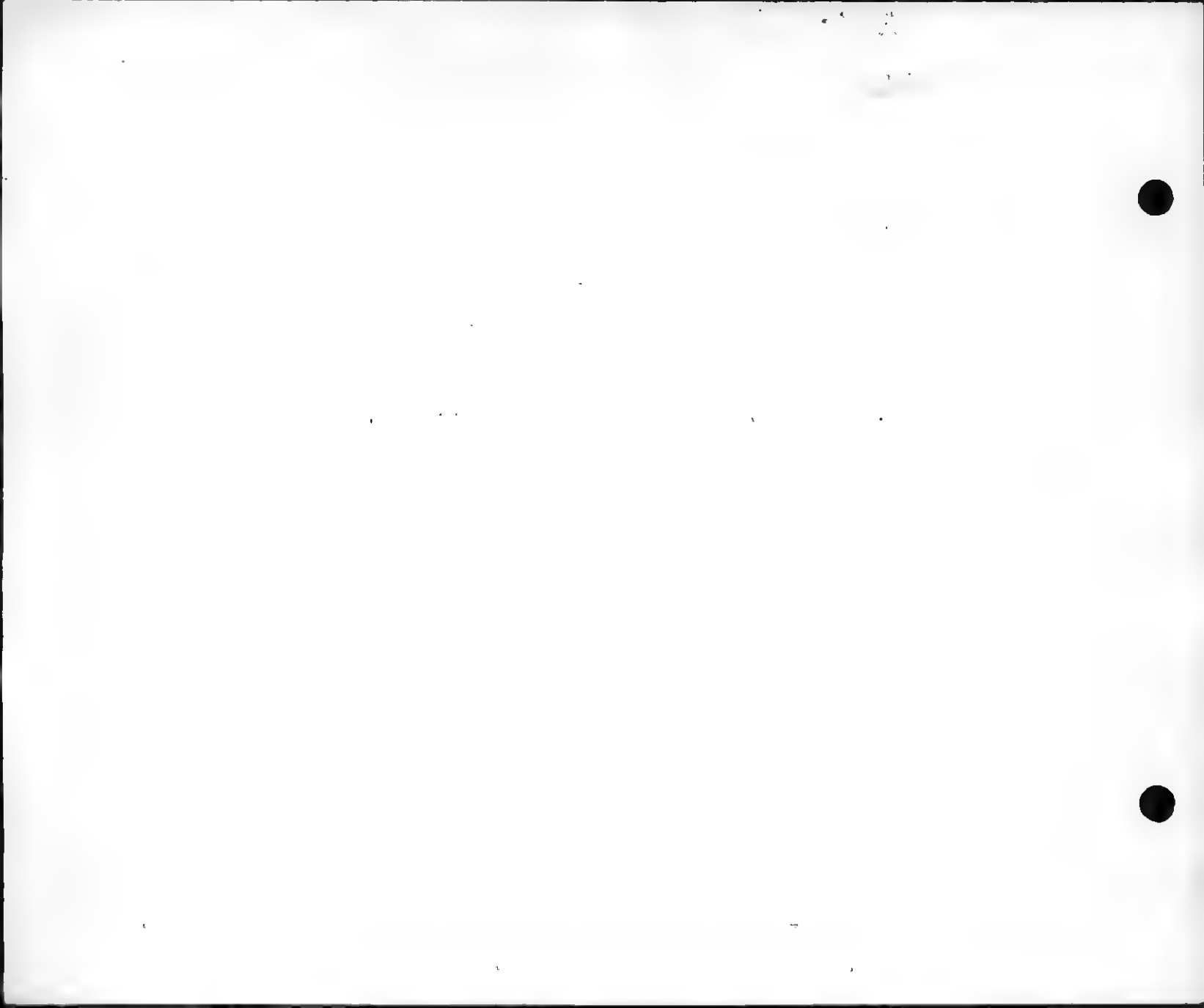
1 (M)
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film 6185 2/8/67 mh

Item #4 Film #3309 1/12/67 DC

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01954		01950	
1. PLACE OF DEATH a COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a STATE Maryland b COUNTY Harford	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Towson		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Towson	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1705 Aberdeen Rd.		d STREET ADDRESS 1705 Aberdeen Rd.	
3. NAME OF DECEASED (Type or print) First ROBERT Middle Walter Last SPEAR		4. DATE OF DEATH Month February Day 1 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> separated	8. DATE OF BIRTH 3-15-1918
9. AGE (in years last birthday) 48 yrs		10. IF UNDER 1 YEAR Months 1 Days 6 Hours 11 Min 67	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11b. KIND OF BUSINESS OR INDUSTRY Maind	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Capt. Tyler W. Spear	
14. MOTHER'S MAIDEN NAME Helen M. Wagner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) yes WW2	
16. SOCIAL SECURITY NO. WW2		17. INFORMANT Mrs Helen Eisenhardt Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Occlusive coronary arteriosclerotic heart disease. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Rudiger Breitenecker, M.D.		22. DATE SIGNED 2/2/67	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 2-4-67	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Kuck, Inc Baltimore, Md.		25a. REC'D BY REGISTRAR 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01955

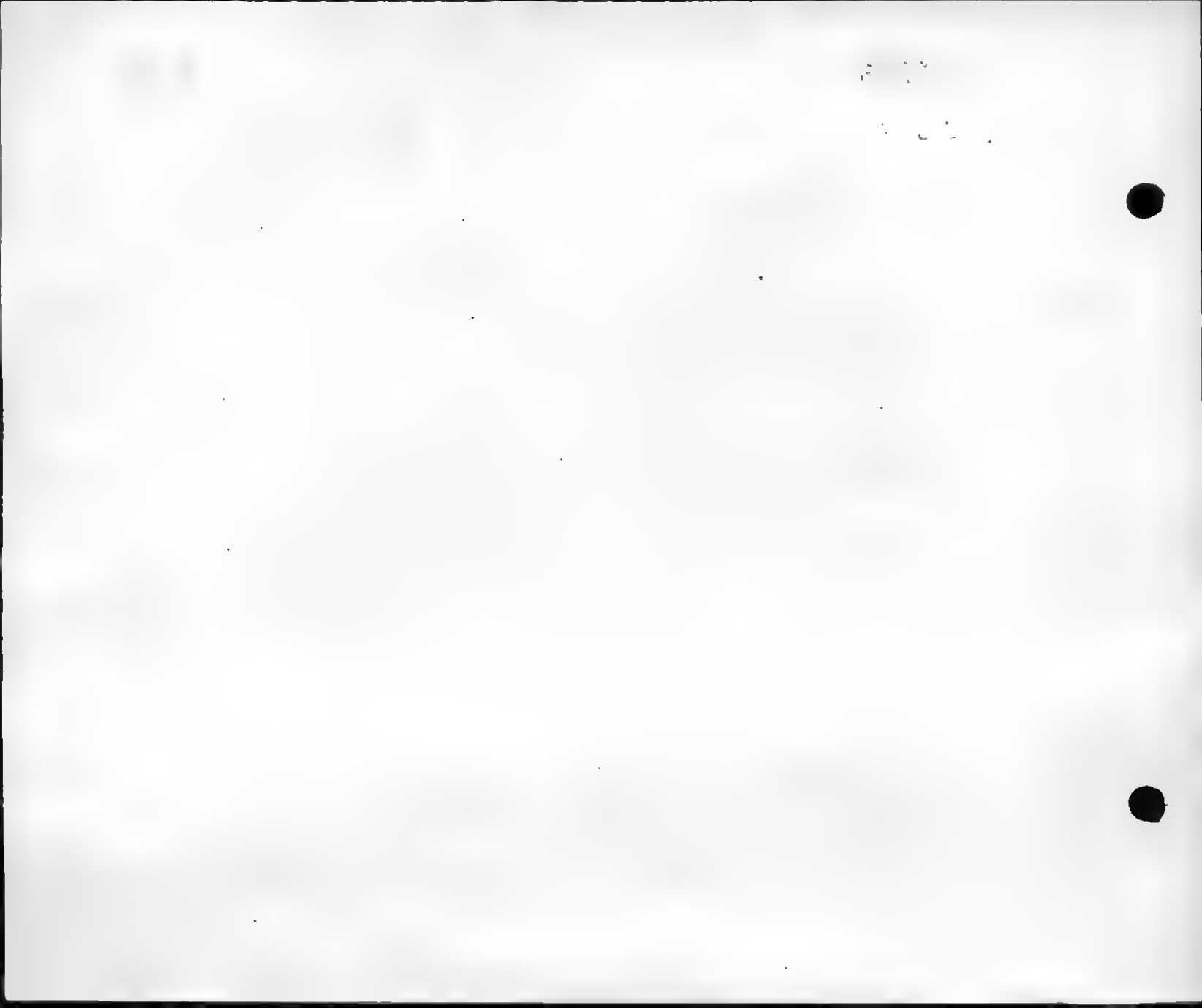
CERTIFICATE OF DEATH

01951

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUMMIT Nursing Home		e. STREET ADDRESS 19 N. Belle Grove Rd	
3. NAME OF DECEASED (Type or print) First ANNA Middle E. Last SPICES		4. DATE OF DEATH Month 2 - Day 17 - Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCT. 28, 1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Reinhold F. Tribull		14. MOTHER'S MAIDEN NAME Elizabeth Richstein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-2247	
17. INFORMANT Mrs. CARROLL T. Giese SR.		Address CATONSVILLE Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4/201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 14 days 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-11-1957 to 2-17-1967 , that (I) (we) last saw the deceased alive on 2-16-1967 , and that death occurred at 2:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallagher Sr.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher Sr.		22d. ADDRESS 6209 Frederick Ave. Balt. 21228 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-20-67	
23c. NAME OF CEMETERY OR CREMATORY Louden PK. Cem.		23d. LOCATION (City or Town) (County) (State) BALTIMORE Md.	
24. FUNERAL DIRECTOR E. S. Mac Nabb		25a. REC'D BY REGISTRAR FEB 21 1967	
ADDRESS 301 Frederick Rd Balt. Md. 21208		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

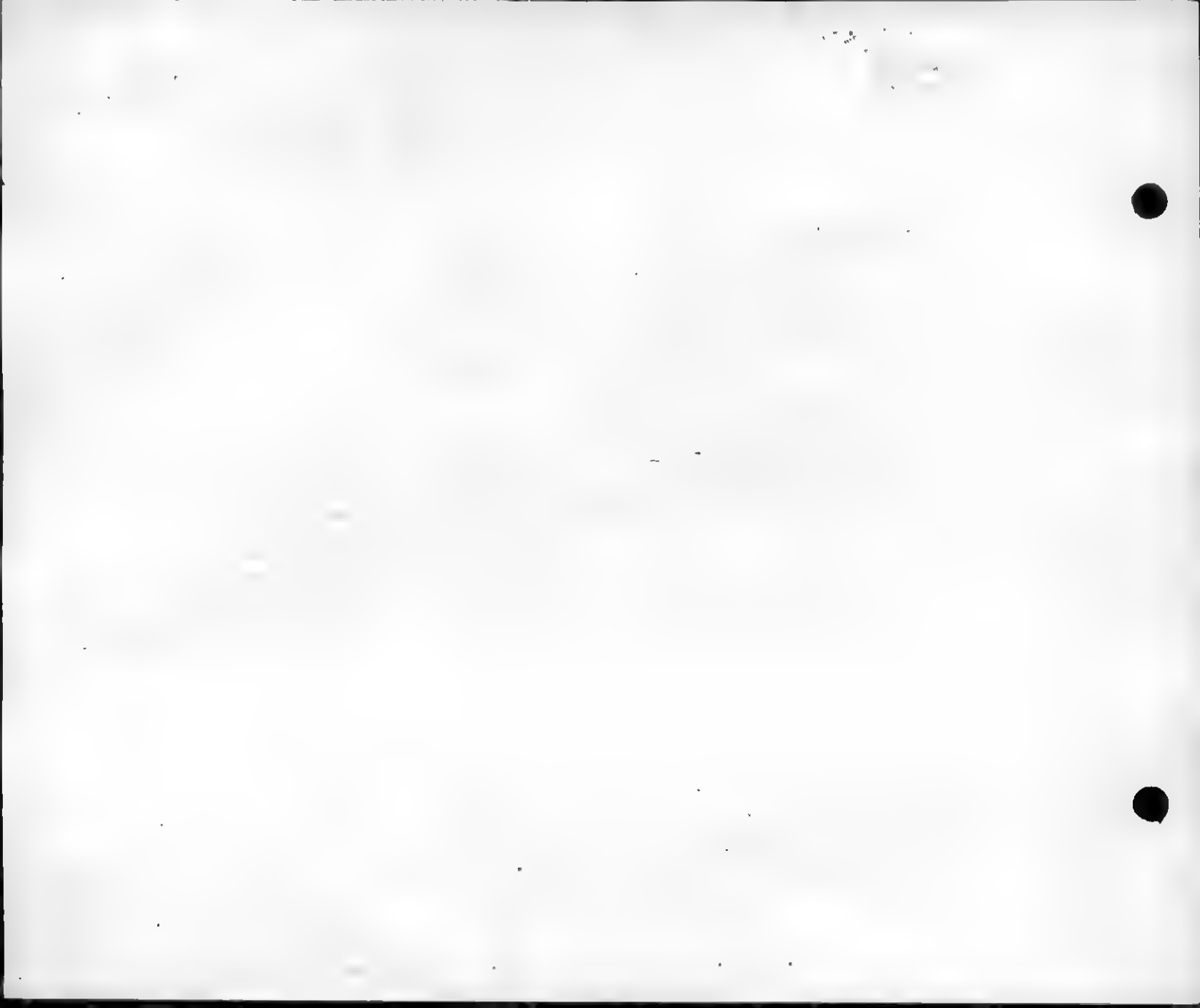
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01956

CERTIFICATE OF DEATH

01952

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Baltimore 21206		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital						d. STREET ADDRESS 4516 Kenwood Ave.					
3. NAME OF DECEASED (Type or print) First Middle Last Anna (Annetta) SPINA						4. DATE OF DEATH Month Day Year February 20, 1967					
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1893		9. AGE (In years lost birthday) yrs 73		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Sicily - Italy				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Brocato						14. MOTHER'S MAIDEN NAME Josephine Sabatino					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 216-28-7524		17. INFORMANT Address Carmel Spina 4516 Kenwood Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Coronary arteriosclerosis and calcification.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/11/ , 19 67 , to 2/20/ , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/20/ 1967, and that death occurred at 11:20M , from causes and on the date stated above.											
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.						22b. DATE SIGNED February 20, 1967		22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/23/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem				23d. LOCATION (City or town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Dippel Bro's. Inc. 7110 Belair Rd.						25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

01953

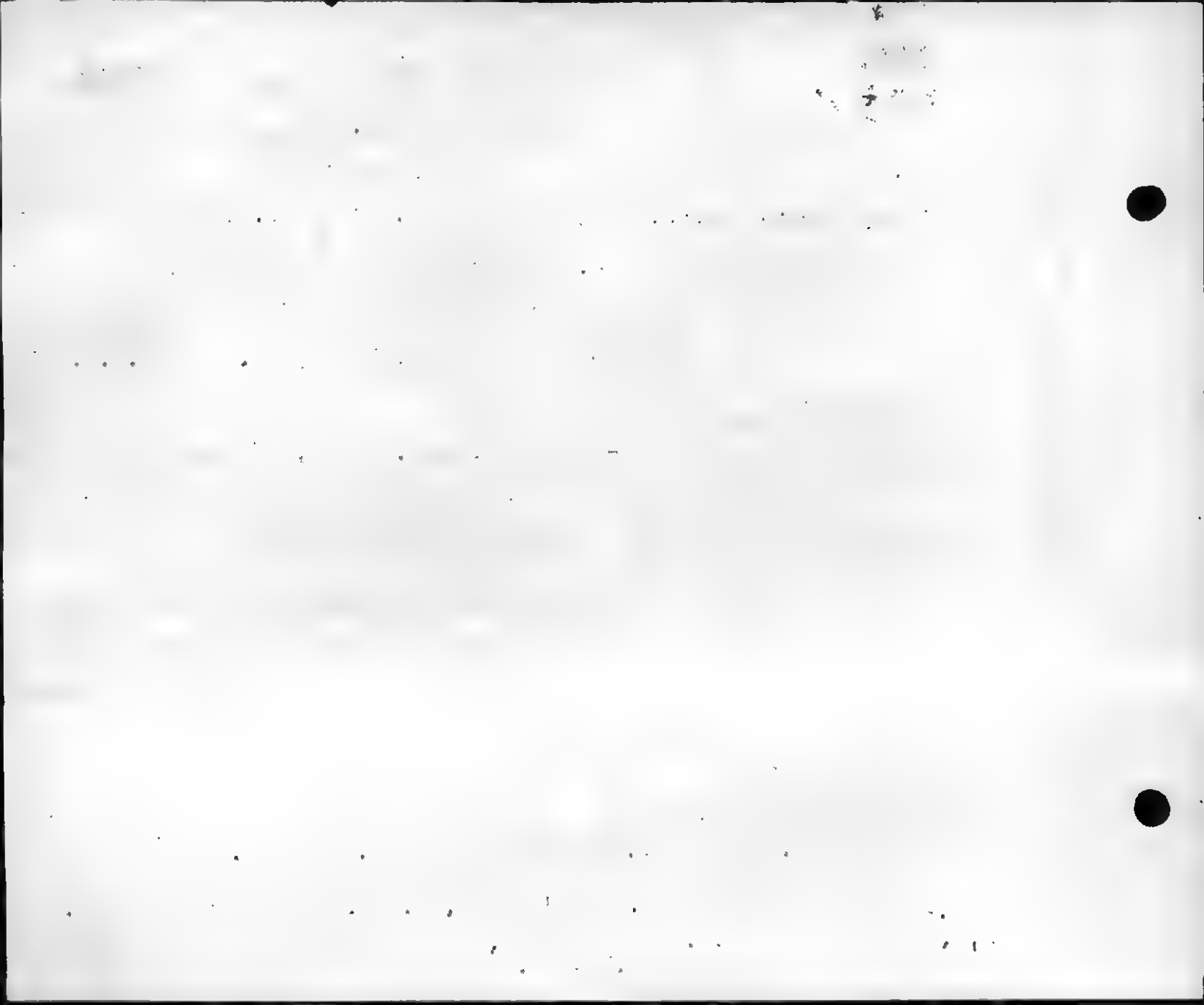
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01953

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa. b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Philadelphia			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 531 W. Luray St. (18140)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dulaney Towson Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle J. Last Stahl			4. DATE OF DEATH Month February Day 7 Year 1967				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/1889	9. AGE (in years last birthday) 77 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Trimborn				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 163-10-3320		17. INFORMANT William H. Stahl, 15 Murray Hill Circle		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure 42 DU TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic heart disease DU TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) pneumonia							INTERVAL BETWEEN ONSET AND DEATH 1 week years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (1) (this hospital) attended the deceased from 11/21 , 19 66 , to 2/7 , 19 67 , that (1) (we) last saw the deceased alive on 2/3 , 19 67 , and that death occurred at 11:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE Dr. F. Cox				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2 Feb 67	
22c. PHYSICIAN'S NAME (Type) Dr. William F. Cox, III				22d. ADDRESS 1118 St. Paul St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.-Burial		23b. DATE THEREOF 2/10/1967		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Luth. Ch. Cem.		23d. LOCATION (City, town or county) (State) Lafayette Hill, Pa.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR DATE 3 10 1967		25b. REGISTRAR'S SIGNATURE J. H. Jones	



0195A

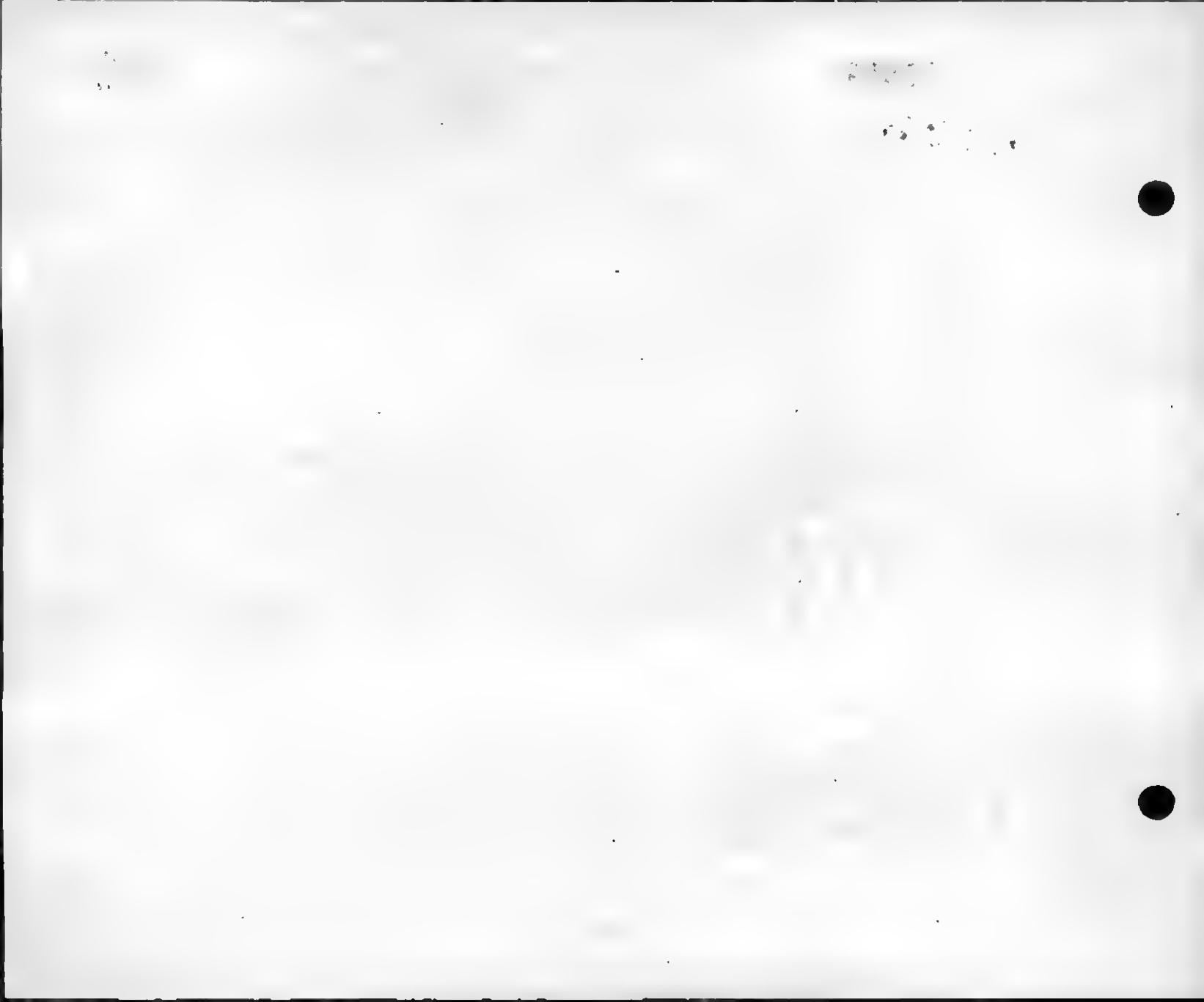
CERTIFICATE OF DEATH

01954

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANSDOWNE</u>		c. LENGTH OF STAY IN 1b <u>12 YRS.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2430 Zion Road</u>		e STREET ADDRESS <u>2430 Zion Road.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>William George Stapf</u>		4 DATE OF DEATH Month Day Year <u>Feb. 20 1967</u>	
5 SEX <u>MALE</u>	6 CO. OR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>JAN 14, 1900</u>
9 AGE (In years last birthday) <u>67</u> yrs		10 UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10b KIND OF BUSINESS OR IND. STRY <u>MEAT PACKING</u>	
11 BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Stapf</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA Hoffman</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>216-03-0957</u>	
17. INFORMANT <u>Pyth Peters</u>		Address <u>2430 Zion Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>January</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>January 20</u> 19 <u>67</u> , and that death occurred at <u>12</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Francis H. Miller</u>		22b. DATE SIGNED <u>2/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis H. Miller</u>		22d. ADDRESS <u>2101 Frederick Ave</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>2-23-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>London Park</u>	23d LOCATION (City or Town) (County) (State) <u>BALTIMORE Md.</u>
24. F. J. L. Schwaiblmair, M.D., M.P.H., Director, Division of Statistical Research and Records, State Department of Health, 301 W. Preston Street, Baltimore, Maryland 21201		25a REGD BY REGISTRAR DATE <u>FEB 23 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Francis H. Miller</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01959

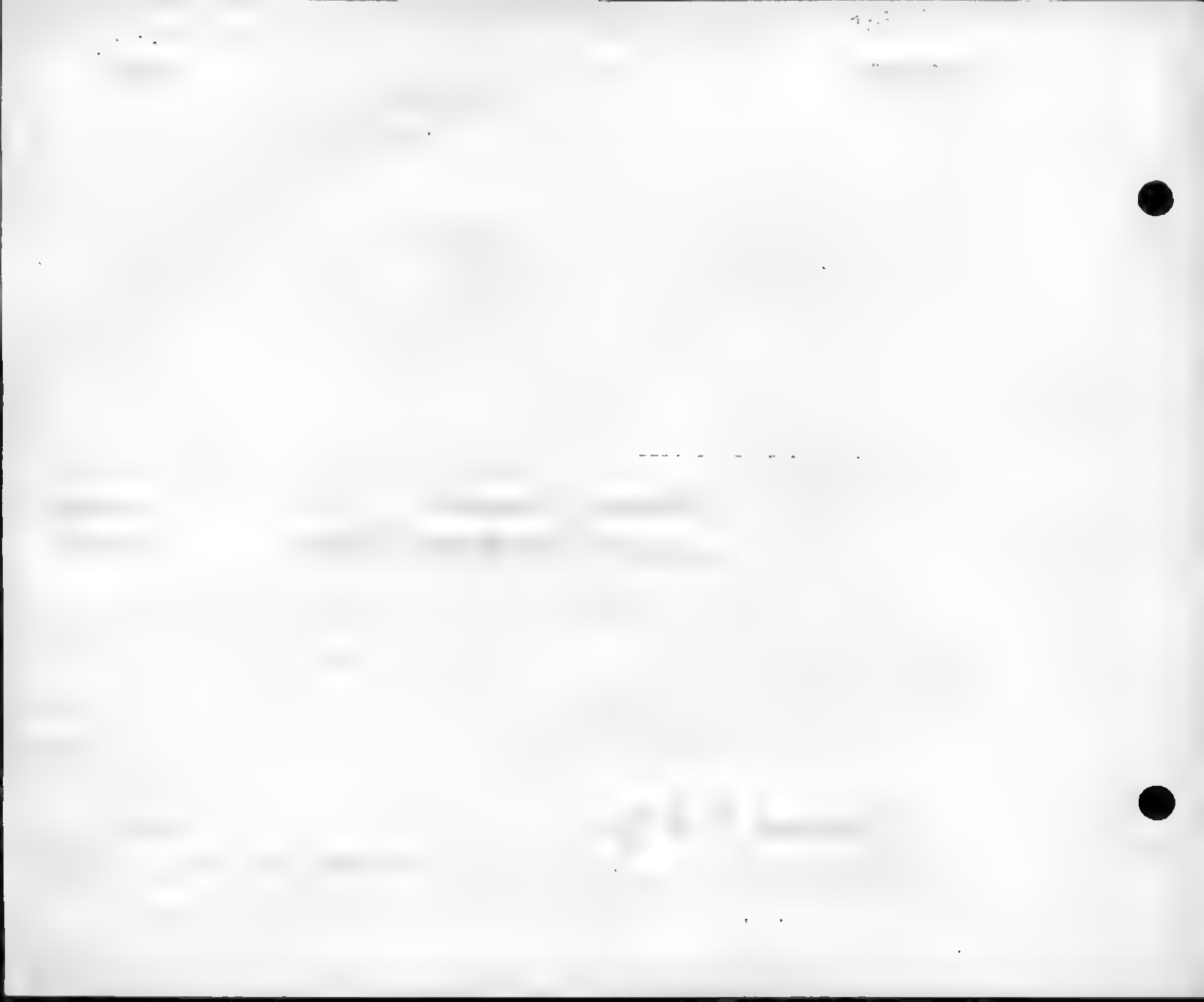
CERTIFICATE OF DEATH

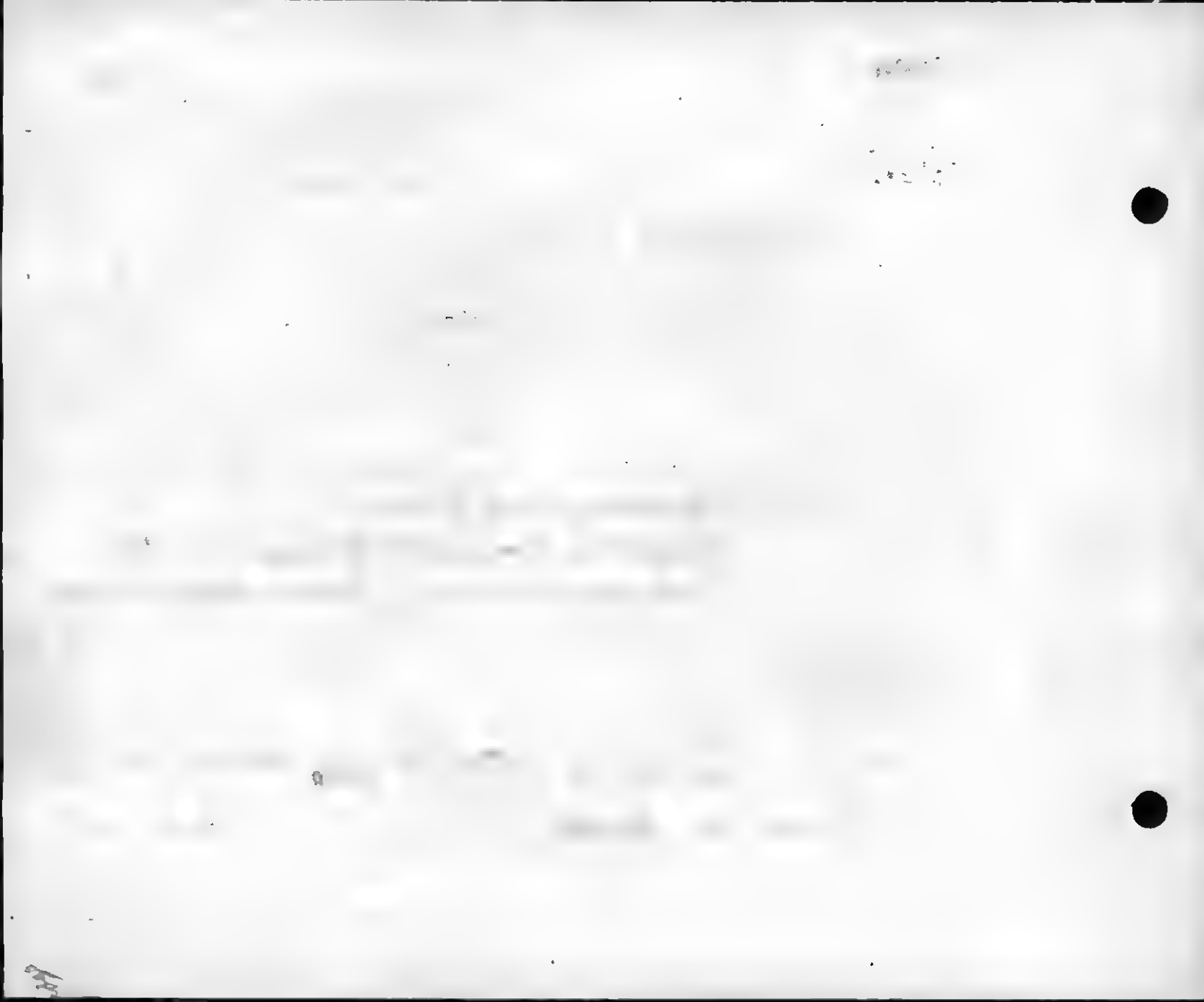
01955

1 PLACE OF DEATH a. COUNTY <u>Towson</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2,35 1/2</u>		d STREET ADDRESS <u>2,35 1/2</u>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>George</u> Last <u>Blum</u>		4 DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 10, 1877</u>
9 AGE (In years last birthday) <u>89</u> yrs		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John George Blum</u>		14 MOTHER'S MAIDEN NAME <u>Kraft</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>1-2-3-4-5-6-7-8-9-0</u>	
17 INFORMANT <u>John E. Day</u>		Address <u>1-2-3-4-5-6-7-8-9-0</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchitis - pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD with cardiac failure</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1958</u> , to <u>Feb. 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb. 7, 1967</u> , and that death occurred at <u>2 p.m.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Newland E. Day</u>		22b. DATE SIGNED <u>February 8, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Newland E. Day, M.D.</u>		22d. ADDRESS <u>4-8-33 St Baltimore Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 9, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Road Towson 4, Maryland</u>		25a REC'D BY REGISTRAR DATE <u>FEB 9 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01961

01957

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>City of Baltimore</u>			d. STREET ADDRESS <u>1533 Bolton Street</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>College Manor</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Berkeley</u> Last <u>Stevenson</u>		4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1967</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 1, 1868</u>		9. AGE (In years last birthday) <u>98</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Prob. Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>WILLIAM HENRY STEVENSON</u>		14. MOTHER'S MAIDEN NAME <u>FANNY MADISON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>214-54-3369</u>		17. INFORMANT: <u>Dec'd. Atty. & Dec'd.) Hinkley & Singley, Balto., Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASCD</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1st, 1960</u> to <u>Feb 21, 1967</u> , that (I) last saw the deceased alive on <u>Feb 21, 1967</u> , and that death occurred at <u>10:10 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Ann Dugan</u>				22b. DATE SIGNED <u>2/24/67</u>		22c. PHYSICIAN'S NAME (Type) <u>ANN DUGAN</u>	
22d. ADDRESS <u>15 E BIDDLE ST BALTIMORE MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Feb. 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Stewart & Mowen Co. 108 N. North Av., City 1</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>William V. V...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01962

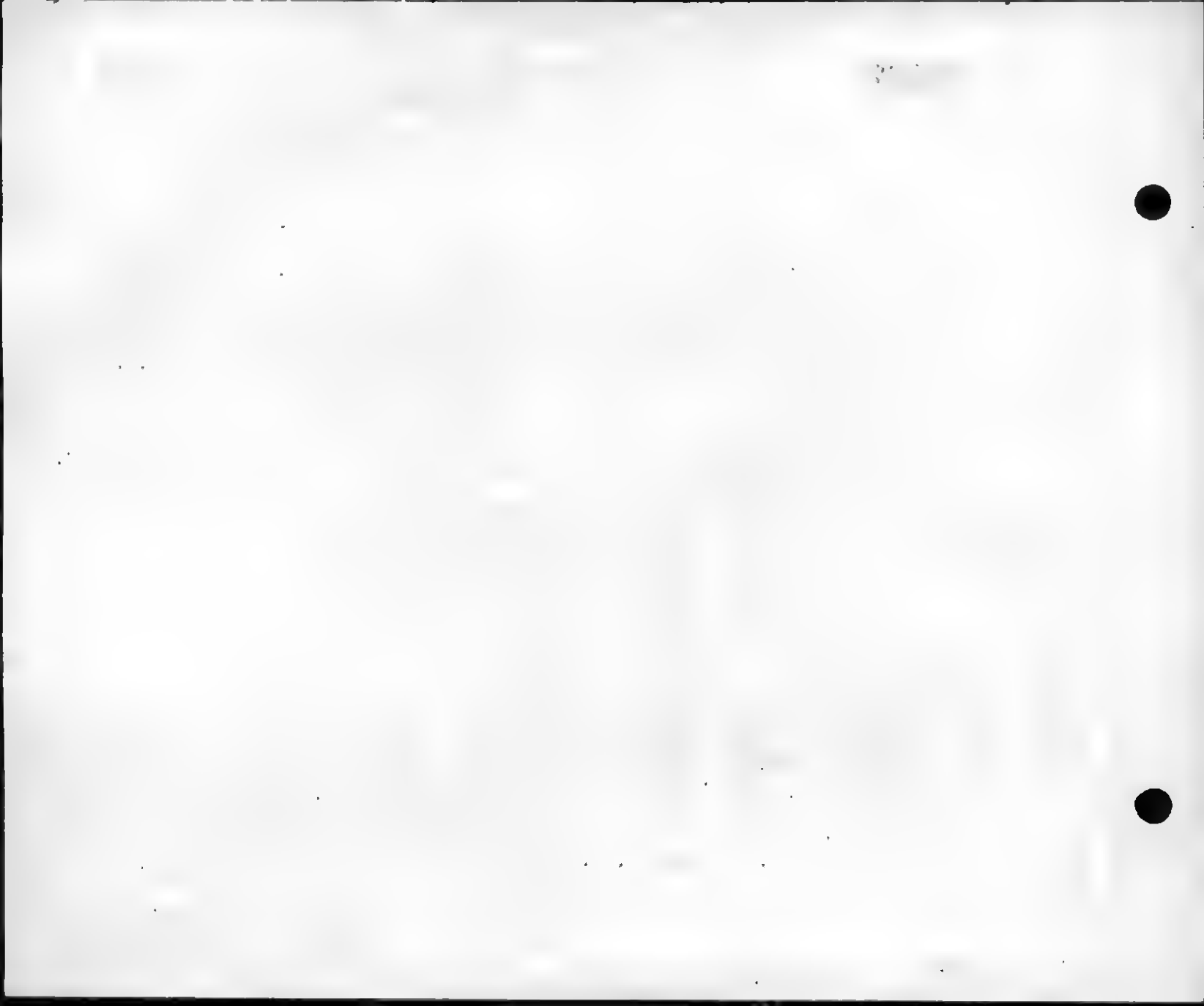
CERTIFICATE OF DEATH

01958

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 16 8 days		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admssion) a. STATE Maryland b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				e. STREET ADDRESS 5403 North Ave & Jackson St.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle EWING Last STEWART		4. DATE OF DEATH Month February Day 22 Year 19 67		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/19/19		9. AGE (in years last birthday) 47 yrs		10. IF UNDER 1 YEAR Months 1 Days 22 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Stewart				14. MOTHER'S MAIDEN NAME Josephine Ewing			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO		17. INFORMANT Clinical Rcds. VA Hospital, Ft Howard, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BILATERAL LOBAR PNEUMONIA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from Feb. 14, 19 67 to Feb. 22, 19 67 , that (H) (we) last saw the deceased alive on Feb. 22, 19 67 , and that death occurred at 10:50 AM , from causes and on the date stated above.							
22a. SIGNATURE John D. Talbert				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/23/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.				22d. ADDRESS VA Hospital, Fort Howard, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/25/19 67		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City or Town) (County) (State) Easton, Md.	
24. FUNERAL DIRECTOR NEWNAM Funeral Home				25a. REC'D BY REGISTRAR DATE FEB 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8, 9 Film 105 2/15/67 mo

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

01963

01959

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution. Reside re before admission) a STATE Maryland b COUNTY Baltimore			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall				c LENGTH OF STAY IN 1b 2 YRS			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4006 Pinedale Drive				d STREET ADDRESS 4006 Pinedale Drive			
3 NAME OF DECEASED (Type or print) Edmund Sylvester Stillmock				4 DATE OF DEATH Feb. 7, 1967			
5 SEX Male	6 COLOR OR RACE Caucasian	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1922 Feb. 10, 1922	9 AGE (In years last birthday) 45	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weather Analyst			10b KIND OF BUSINESS OR INDUSTRY Aberdeen Prov. Gr. Omaha, Neb.		11 BIRTHPLACE (State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME Martin Stillmock				14 MOTHER'S MAIDEN NAME Barbara			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16 SOCIAL SECURITY NO WW11 - 1958		17 INFORMANT Winifred N. Stillmock		Address 4006 Pinedale Dr.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 416X Rheuma Le Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH under	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John C. Hyle		EXAMINER'S NAME (Type) John C. Hyle M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2-7-67	
				ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		7527 Belair Rd. Overlea 2/7/67	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF Feb. 10, 67		23c NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Catonsville Md.		23d LOCATION (City & Town) (County) (State)	
24 FUNERAL DIRECTOR Dippel Brothers Inc. 7110 Belair Rd.				25a REC'D BY REGISTRAR 9 1967		25b REGISTRAR'S SIGNATURE James Judas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1911

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

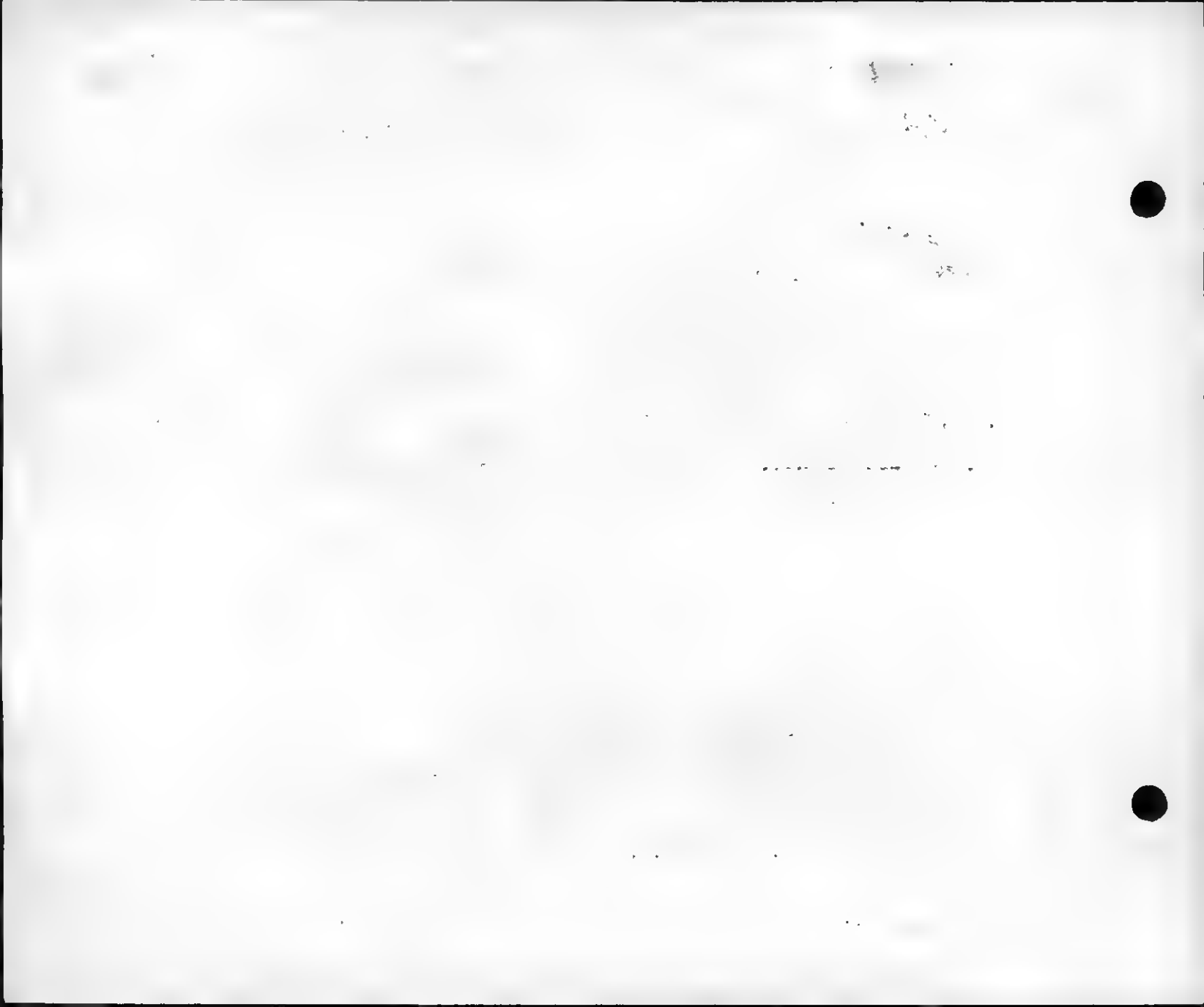
01964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18-21, Film G388 5/15/67

01960

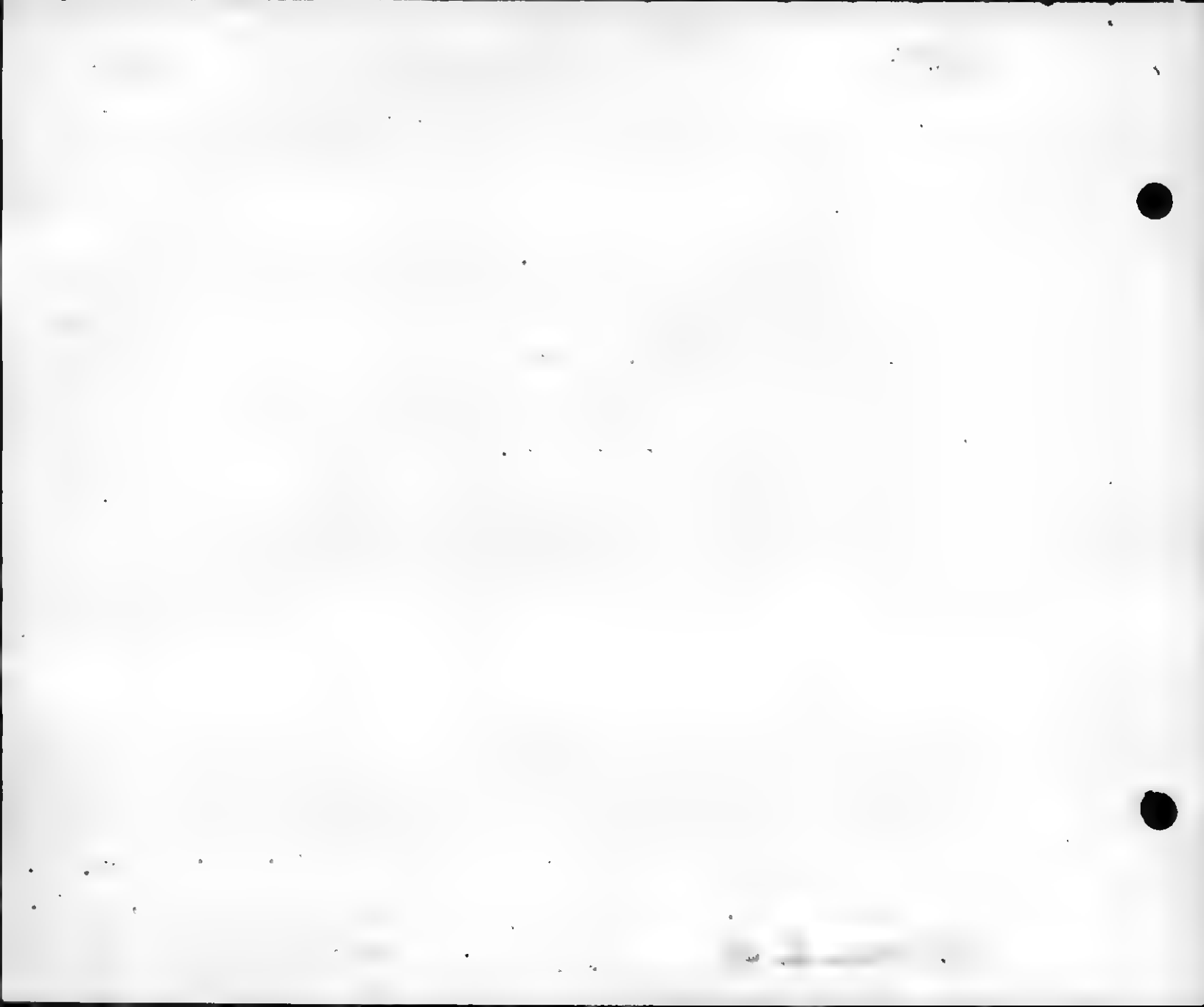
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson-rural				c. LENGTH OF STAY IN 1b 3 YEARS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center				d. STREET ADDRESS 924 Starbit Rd			
3 NAME OF DECEASED (Type or print) First Middle Last Charles DAWCAN Strawbridge				4 DATE OF DEATH Month Day Year 2 18 19 67			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 29, 1903	9 AGE (In years last birthday) 34 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEVER EMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME F. NEILSON STRAWBRIDGE				14. MOTHER'S MAIDEN NAME CONSTANCE BOWIE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO NONE		17. INFORMANT F. NEILSON STRAWBRIDGE			Address SAME AS 2-D
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subdural hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell from chair or high stool on 2-12-67					
20c. TIME OF INJURY Month, Day, Year Hour 2-12- 19 67 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home		20f. (City or town, (County) (State) Baltimore Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2/19/67	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Cremation		23b. DATE THEREOF 2-20-67		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Jensen		ADDRESS 1050 YORK ROAD TOWSON, MARYLAND 21204		25a. REC'D BY REGISTRAR FEB 21 1967		25b. REGISTRAR'S SIGNATURE <i>William A. Jensen</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> 01965 MARYLAND STATE DEPARTMENT OF HEALTH 01961 </div> <div style="text-align: center;"> DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>							
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELAIR</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>				d. STREET ADDRESS <u>ROUTE 1 BOX 61</u>							
3. NAME OF DECEASED (Type or print) <u>MILTON E. STREET</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>26</u> Year <u>1967</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAUC.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-04-01</u>		9. AGE (in years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plaster--Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Const. & Farm</u>				11. BIRTHPLACE (County & State, or foreign country) <u>HARFORD CO., MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RICHARD M. STREET</u>				14. MOTHER'S MAIDEN NAME <u>BESSIE Ella Bull</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-18-9179-A</u>				17. INFORMANT Address <u>Wife, Same as 2 C & D</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cor Pulmonale</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lymphosarcoma of mediastinum</u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 12,</u> 19 <u>67</u> , to <u>Feb. 26,</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 26,</u> 19 <u>67</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>C. C. SHIH</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>Feb. 26, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. C. SHIH M.D.</u>				22d. ADDRESS <u>Greater Balto. Med. Center, Balto., Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1 Mar. 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Run Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Havre de Grace, Md.</u>			
24. FUNERAL DIRECTOR <u>Walter H. Deacon</u>				REC'D BY REGISTRAR <u>Aberdeen, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

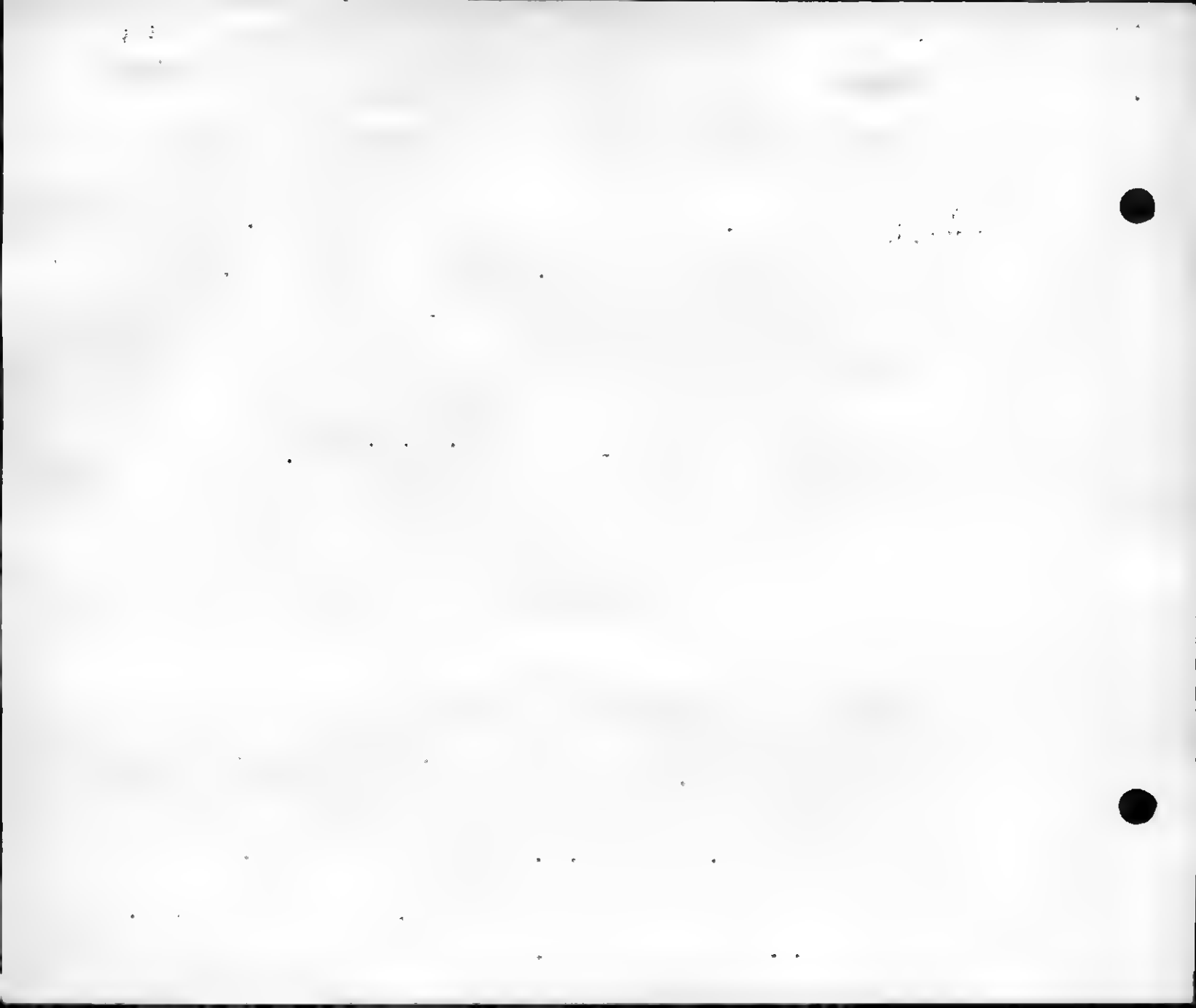
01966

01962

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b Catonsville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6010 Moorehead Rd.		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 6010 Moorehead Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) William T. Strehlau First Middle Last		4 DATE OF DEATH Feb. 6 1967 Month Day Year	
5 SEX M	6 COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-12-94
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 72 Months Days Hours Min
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Strehlau		14. MOTHER'S MAIDEN NAME Nellie Sauner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-03-4799A	
17. INFORMANT Mrs. Wm. T. Strehlau 6010 Moorehead Rd.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Jan. 4 , 1967, to Feb. 6 , 1967, that (I) (we) saw the deceased alive on Feb. 6 , 1967, and that death occurred at 4:10AM , from causes and on the date stated above			
22a. SIGNATURE Leo J. Gaver, M.D.		22b. DATE SIGNED 2/6/67	
22c. PHYSICIAN'S NAME (Type) Leo J. Gaver, M.D.		22d. ADDRESS 1 Mallow Hill Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-9-67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F.D.-4101 Edmondson Ave.		25a. REC'D BY REGISTRAR FEB 8 1967 DATE	
		25b. REGISTRAR'S SIGNATURE Witzke	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 21 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

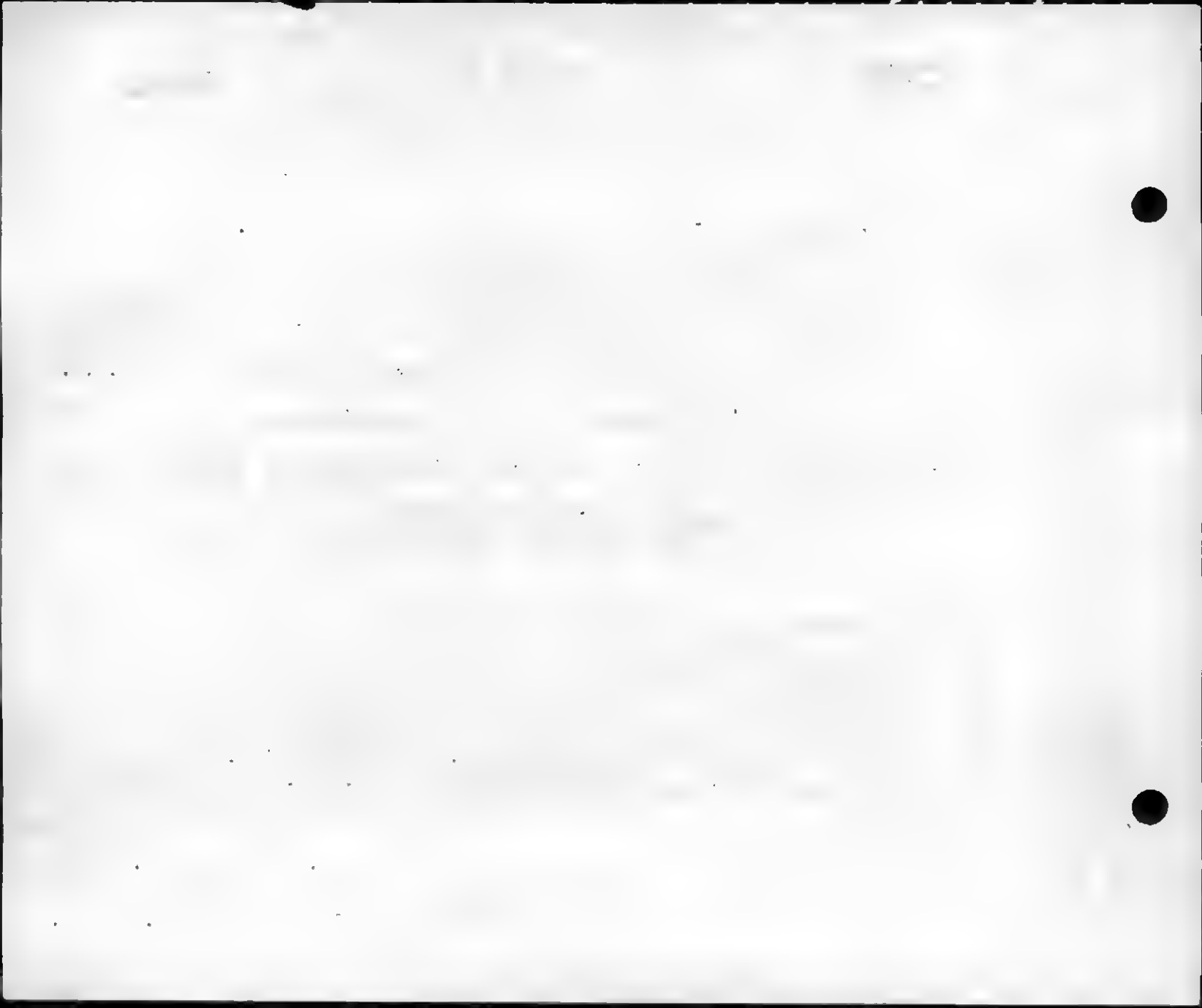
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01967

CERTIFICATE OF DEATH

01963

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lowson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206 d. STREET ADDRESS 4304 Willshire Ave. e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Agnes Middle Madeline Last Strocker				4 DATE OF DEATH Month February Day 7 Year 1967			
5 SEX Female		6 COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 9/8/99	
9 AGE (in years last birthday) 67 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Wilmer Linzey		14. MOTHER'S MAIDEN NAME Agnes Viola Angel		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 212-14-9320		17. INFORMANT Mr Henry Strocker		Address 4304 Wilshire Avenue 6		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis generalized DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of the left breast DUE TO (c)	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 28 , 19 67 , to Feb. 7 , 19 67 , that (I) (we) last saw the deceased alive on Feb. 7 , 19 67 , and that death occurred at 8.55 M. from causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) [Signature]	
22d. ADDRESS 620 York Rd. Baltimore, Md. 21204				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-11-1967		23c. NAME OF CEMETERY OR CREMATORY Frankwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR [Signature]		ADDRESS 36		25a. REC'D BY REGISTRAR [Signature]		25b. REGISTRAR'S SIGNATURE [Signature]	
DATE FEB 14 1967							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01966

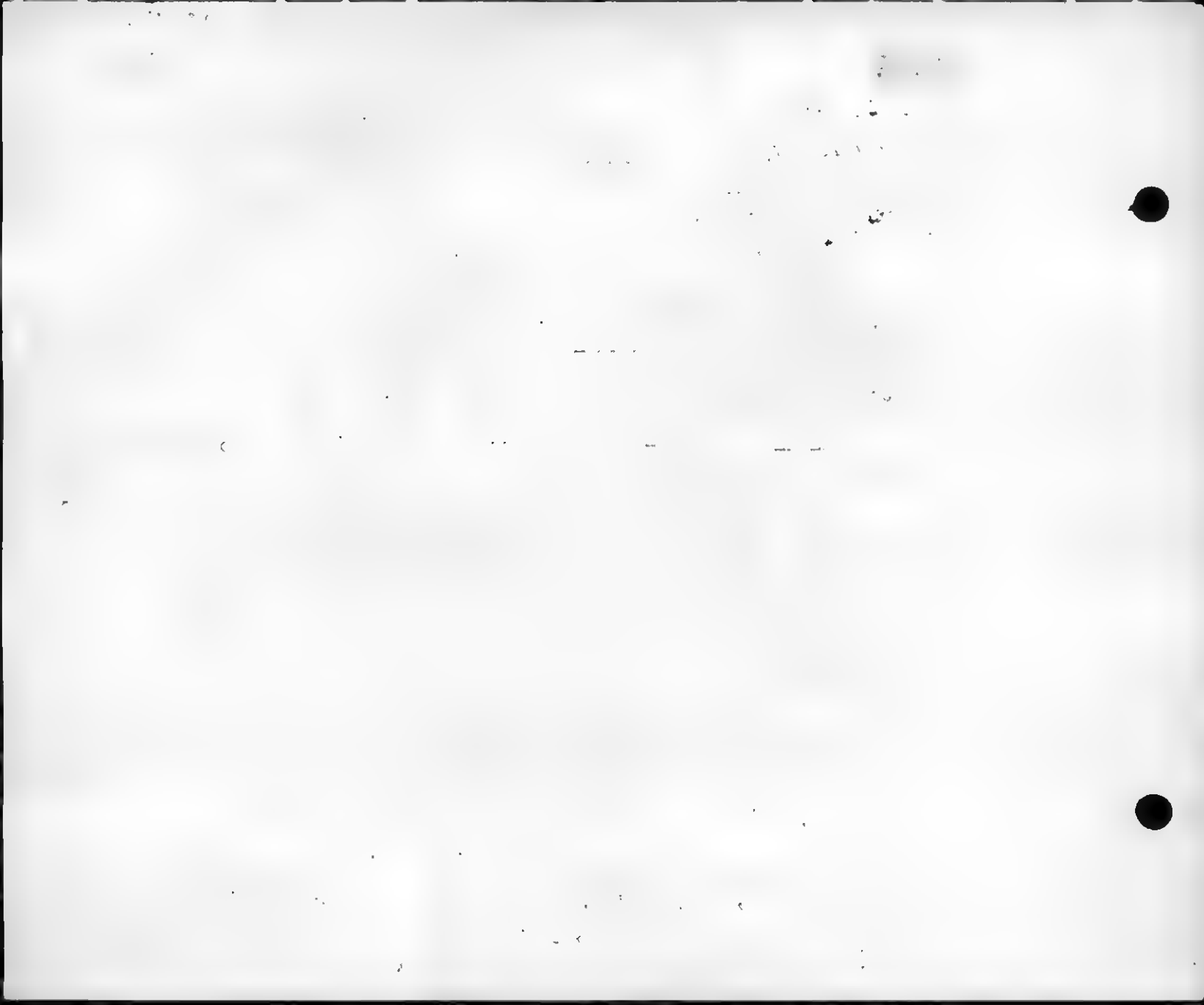
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01964

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b 3 Months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Forrest Haven Rest Home e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mill d. STREET ADDRESS 111 Gwynnbrook Avenue			
3. NAME OF DECEASED (Type or print) Maryanna First Maryanna Middle Szymborski Last Szymborski				4. DATE OF DEATH February 19 1967 Month February Day 19 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27 1887	
9. AGE (in years last birthday) 79 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME John Przyborowski		14. MOTHER'S MAIDEN NAME Anna UNK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 218-10-3027B		17. INFORMANT Marie Urbanski		Address 31 N Montford Avenue		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) A.O.V.D. E. PULMONARY EMBOLISM DUE TO (c) UNDERLYING CAUSE LAST.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 2/1 , 1966, to 2/19 , 1967, that (I) (we) last saw the deceased alive on 2/19 , 1967, and that death occurred at M , from the causes and on the date stated above.		22a. SIGNATURE John Shaw		22b. DATE SIGNED 2/20/67	
22c. PHYSICIAN'S NAME (Type) JOHN SHAW		22d. ADDRESS 5800 EDMONDSON AVE		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. M.D. ATTENDING PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 22, 1967		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION (City, town or county) (State) German Hill Road Md	
24. FUNERAL DIRECTOR The Dippel Brothers Inc		ADDRESS 1800 E Lombard Street		25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01969

CERTIFICATE OF DEATH

01965

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY P 11			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 5 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1816 SUTTON AVENUE			
3. NAME OF DECEASED (Type or print) First JOHN Middle WALTER Last TAVENNER				4. DATE OF DEATH Month FEBRUARY Day 13 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 29, 1895		9. AGE (in years, last birthday) yrs 71	10. FUNERAL 1 YEAR Months 1 Days 13 Hours 13 Min 13	11. IF UNDER 24 HRS Hours 13 Min 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (County & State, or foreign country) DELAWARE, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALDOLE TAVENNER				14. MOTHER'S MAIDEN NAME WILLAMENA DARNELL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO 705 07 63 75		17. INFORMANT CLIN. REC. VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INFECTED CARDIAC ANEURYSM (c) ARTERIOSCLEROTIC HEART DISEASE, YEARS							INTERVAL BETWEEN DEATH AND DEATH RECENT WEEKS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE, YEARS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 2/8/67 , 19 67 to 2/13/67 , 19 67 , that (X) (we) last saw the deceased alive on 2/13/67 , 19 67 , and the death occurred at 5:10 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Sheldon E. Kalmutz</i>		22b. DATE SIGNED 2/13/67		22c. PHYSICIAN'S NAME (Type) SHELDON E. KALMUTZ, M. D.			
22d. ADDRESS VAH FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-16-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD FUNERAL HOME		25a. REC'D BY REGISTRAR FEB 16 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

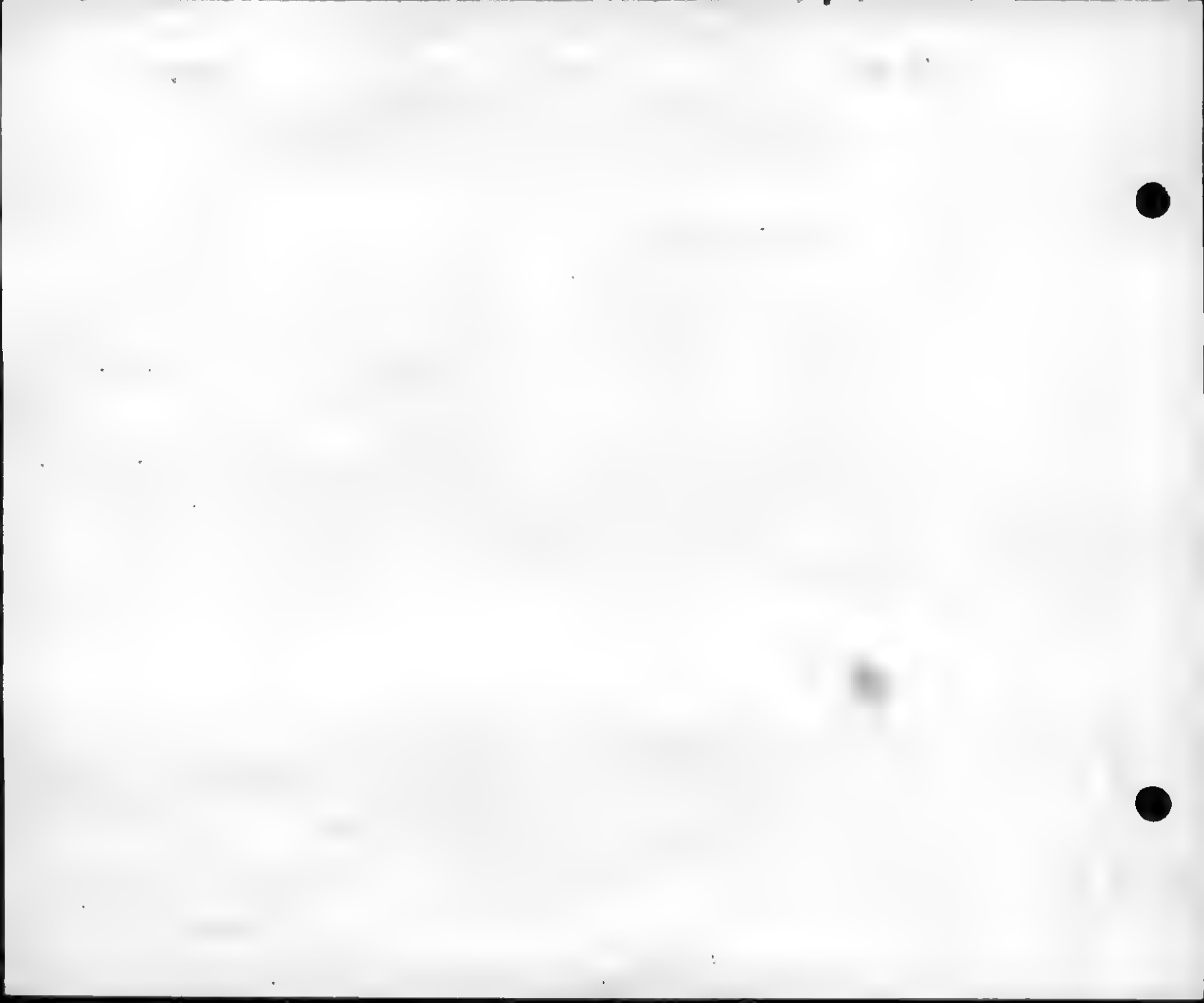
01970

CERTIFICATE OF DEATH

01966

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY in lb 78 DAYS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d STREET ADDRESS 3 E. North Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First WILLIAM Middle B. Last TAYLOR				4 DATE OF DEATH Month FEBRUARY Day 2 Year 19 67			
5 SEX MALE		6 COLOR OR RACE WHITE		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH JUNE 6, 1898	
9 AGE (In years last birthday) yrs 68		10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) PLUMBER		10b KIND OF BUSINESS OR INDUSTRY PLUMBING SHOP		11 BIRTHPLACE (County & State, or foreign country) BEREA, KENTUCKY	
12 CITIZEN OF WHAT COUNTRY? U.S.A.				13 FATHER'S NAME FRANK TAYLOR			
14 MOTHER'S MAIDEN NAME MARGARET WEAVER				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I			
16 SOCIAL SECURITY NO. 219 07 34 10				17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF RIGHT KIDNEY, LIVER AND PANCREAS Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. } due to: CARCINOMA OF LUNG DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from 11/16/66 , 19____, to 2/2/67 , 19____, that (x)(we) last saw the deceased alive on 2/2/67 , 19____, and that death occurred at 8:35 AM from causes and on the date stated above.							
22a. SIGNATURE <i>John D. Talbert</i>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/2/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/6/67		23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>				25a. REC'D BY REGISTRAR JOSEPH N. ZANNINO FUNERAL HOME		25b. REGISTRAR'S SIGNATURE 1967 Charles Judge	

257 S. CONKLING ST. BALTIMORE, MD.



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

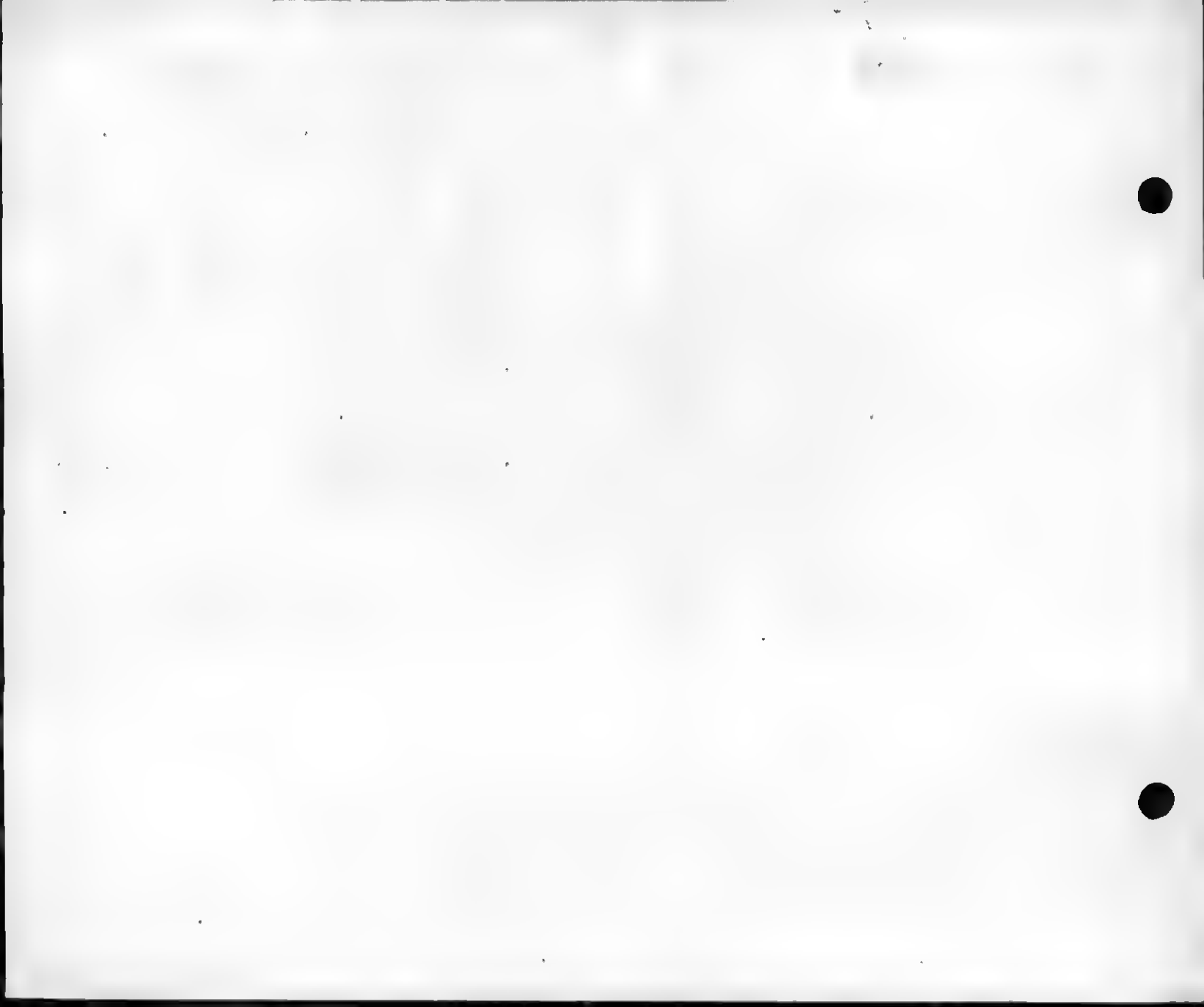
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01977

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01967

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Reisterstown			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 86 Dover Road				d. STREET ADDRESS Box 86 Dover Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First George Middle A. Last Towsend				4. DATE OF DEATH Month February Day 22 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1897	9. AGE (In years last birthday) yrs 69	f. UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		g. UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired from Baltimore Gas & Electric Co.			10b. KIND OF BUSINESS OR INDUSTRY Baltimore City		11. BIRTHPLACE (State or foreign country) Baltimore City		
13. FATHER'S NAME John M. Towsend				14. MOTHER'S MAIDEN NAME Mary E. Belt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) Yes WW I			16. SOCIAL SECURITY NO 212-05-6715		17. INFORMANT Mr. J. Melville Towsend Address Baltimore, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Insufficiency 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive C-V Disease w/ Mitral Murmur; Prastatic Hypertrophy							INTERVAL BETWEEN ONSET AND DEATH 6 mos.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion on death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D. D. Caples			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 2-23-67	
EXAMINER'S NAME (Type) D. D. Caples, M. D.			6 Hanover Rd. Reisterstown, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/25/67		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		23d. LOCATION (City or Town) (County) (State) Boring, Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.				25a. REC'D BY REG. STRAR FEB 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01972

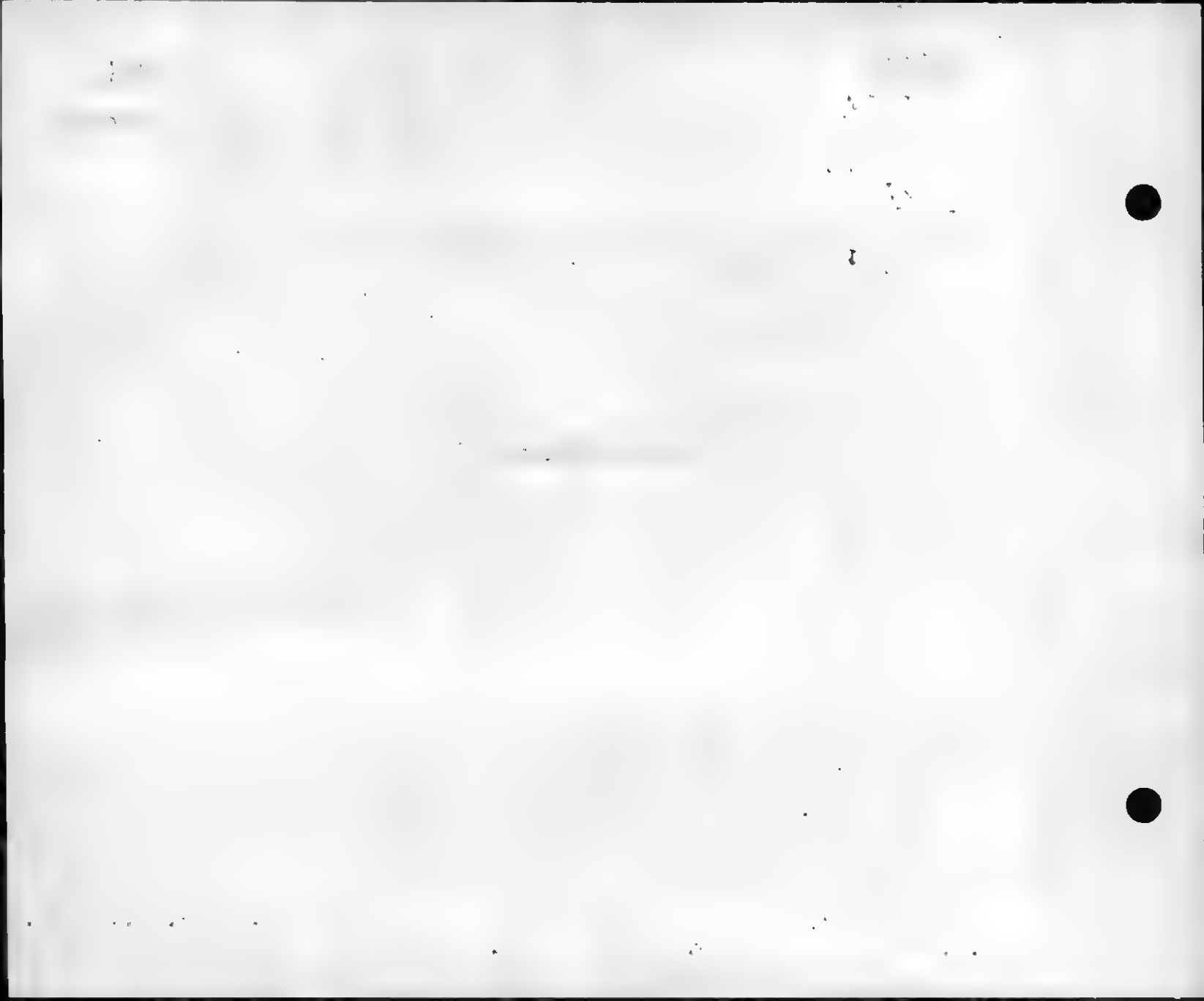
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01968

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GARRISON MD</u> c. LENGTH OF STAY IN ID <u>4 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FOXLEIGH NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: place before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> d. STREET ADDRESS <u>812 SHELLEY ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joanna A. Troja</u> First Middle Last			4. DATE OF DEATH <u>Feb. 4, 1967</u> Month Day Year				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-1881</u> Month Day Year		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>FORT DODGE, IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>DANIEL FITZPATRICK</u>			14. MOTHER'S MAIDEN NAME <u>CONNOLLEY</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-38-8396</u>	17. INFORMANT <u>MRS HELEN A. HARTZELL (SAME)</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u>Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2-1</u> , 19 <u>67</u> , to <u>2-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-3</u> , 19 <u>67</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>David I. Miller</u>				22b. DATE SIGNED <u>2-4-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>		22d. ADDRESS <u>Garrison Rd. Co. 8 Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/7/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monte Maria</u>		23d. LOCATION (City, town or county) (State) <u>Towson, Balto. Co. Md.</u>			
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
DATE <u>FEB 6 1967</u>							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

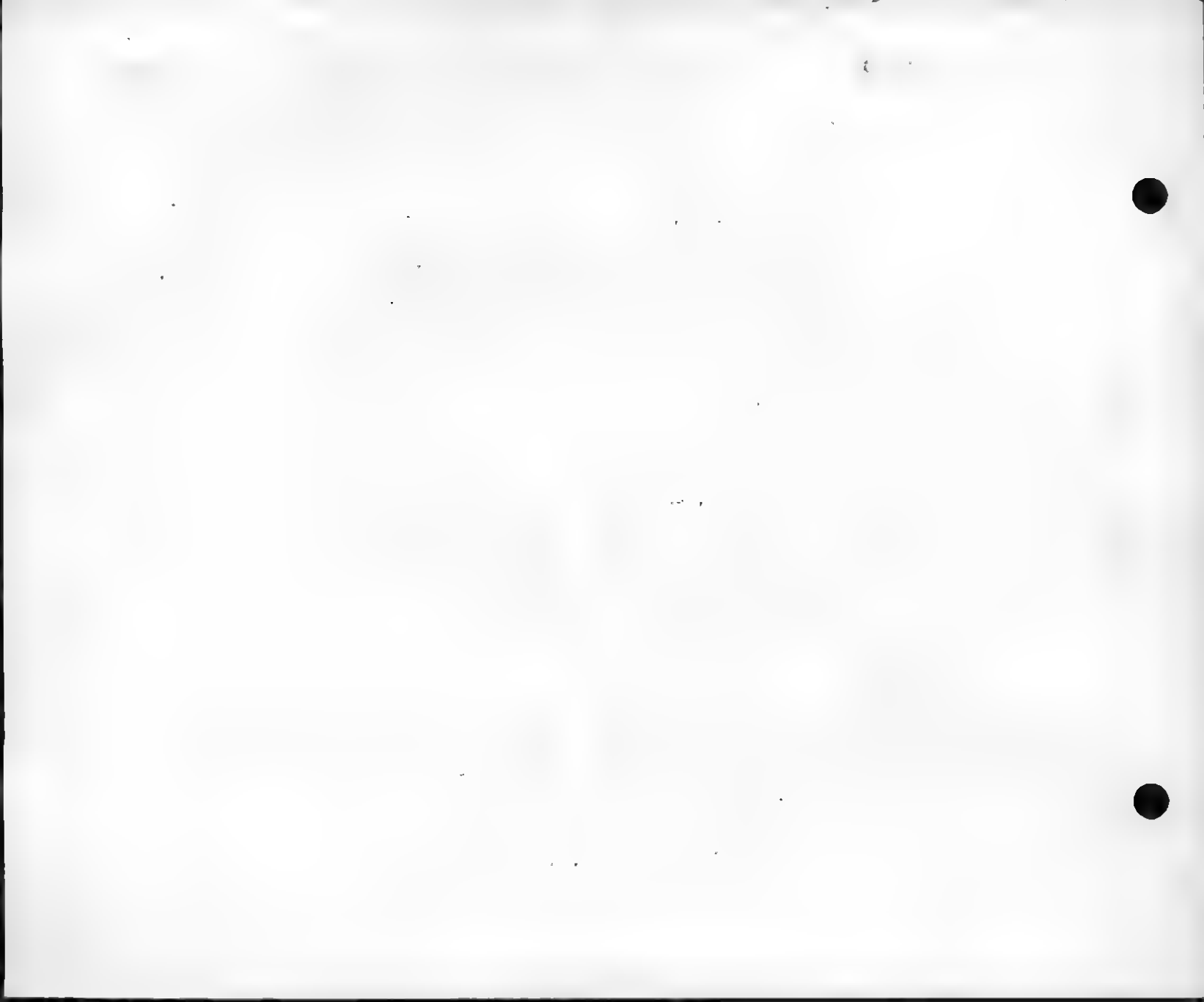
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01973

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01969

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - ROSEDALE				c. LENGTH OF STAY IN TB 157ms			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - RoseDALE				d. STREET ADDRESS Balto. 6			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 613 Patapsco Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AVIS Middle ELIZABETH Last TROVINGER				4. DATE OF DEATH Month February Day 15 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1916	9. AGE (in years last birthday) 50 yrs	10. FUNERAL 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Joseph S. Helms				14. MOTHER'S MAIDEN NAME FRANCES Harwood			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 240-30-4824		17. INFORMANT Charles I. Trovinger Address 613 Patapsco Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured Cerebral Aneurysm 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (name farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breiteneker, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		22. DATE SIGNED 2/15/67		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/18/67		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Philip E. Guch 1211 Chestnut Ave.				25a. REC'D BY REGISTRAR Charles J. Judge		25b. REGISTRAR'S SIGNATURE Charles J. Judge	
DATE FEB 20 1967							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

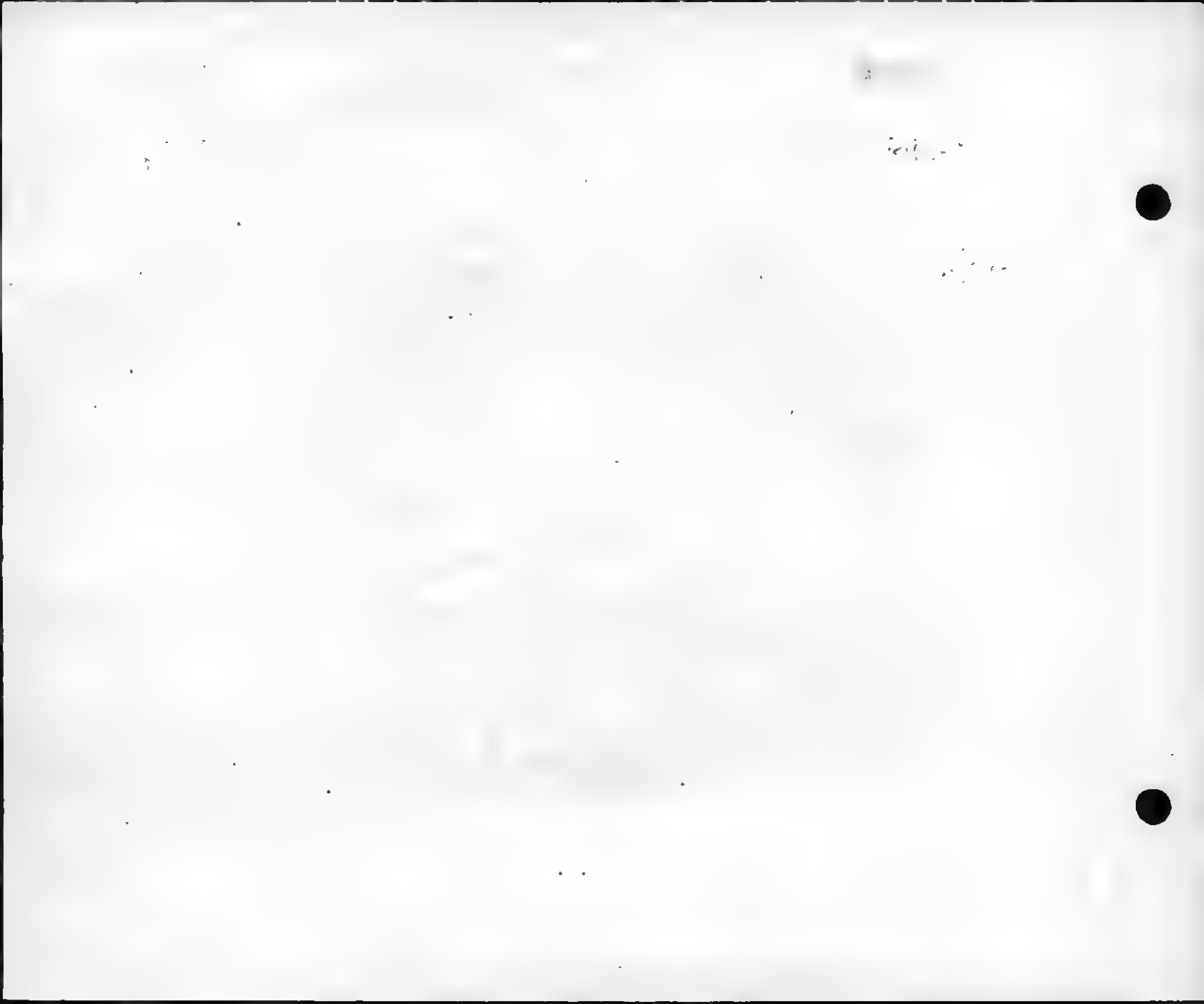
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01974

CERTIFICATE OF DEATH

01970

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY _____	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c LENGTH OF STAY IN 1b 7mths4dys	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Luther Middle Turner Last Turner		4 DATE OF DEATH Month February Day 16 Year 1967	
5 SEX male	6 COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1886
9 AGE (In years birth day) yrs 80		10 UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Callie		14. MOTHER'S MAIDEN NAME Alice	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 228-10-9408	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address SPRING GROVE STATE HOSPITAL	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral, suppurative otitis media			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. _____	
20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)		(County) (State)	
21. I certify that (X) (this hospital) attended the deceased from July 12, 1966 to Feb. 16, 1967 , that (X) (we) last saw the deceased alive on Feb. 16, 1967 , and that death occurred at 8:20 p.m. from causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 2-17-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/19/67	23c. NAME OF CEMETERY OR CREMATORY Goochland Cemetery	23d. LOCATION (City or Town) (County) (State) Virginia
24. FUNERAL DIRECTOR ADOLPHUS HALSTEAD		25a. RECORD BY REGISTRAR DATE FEB 20 1967	
ADDRESS 1206 W North Ave		25b. REGISTRAR'S SIGNATURE U	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

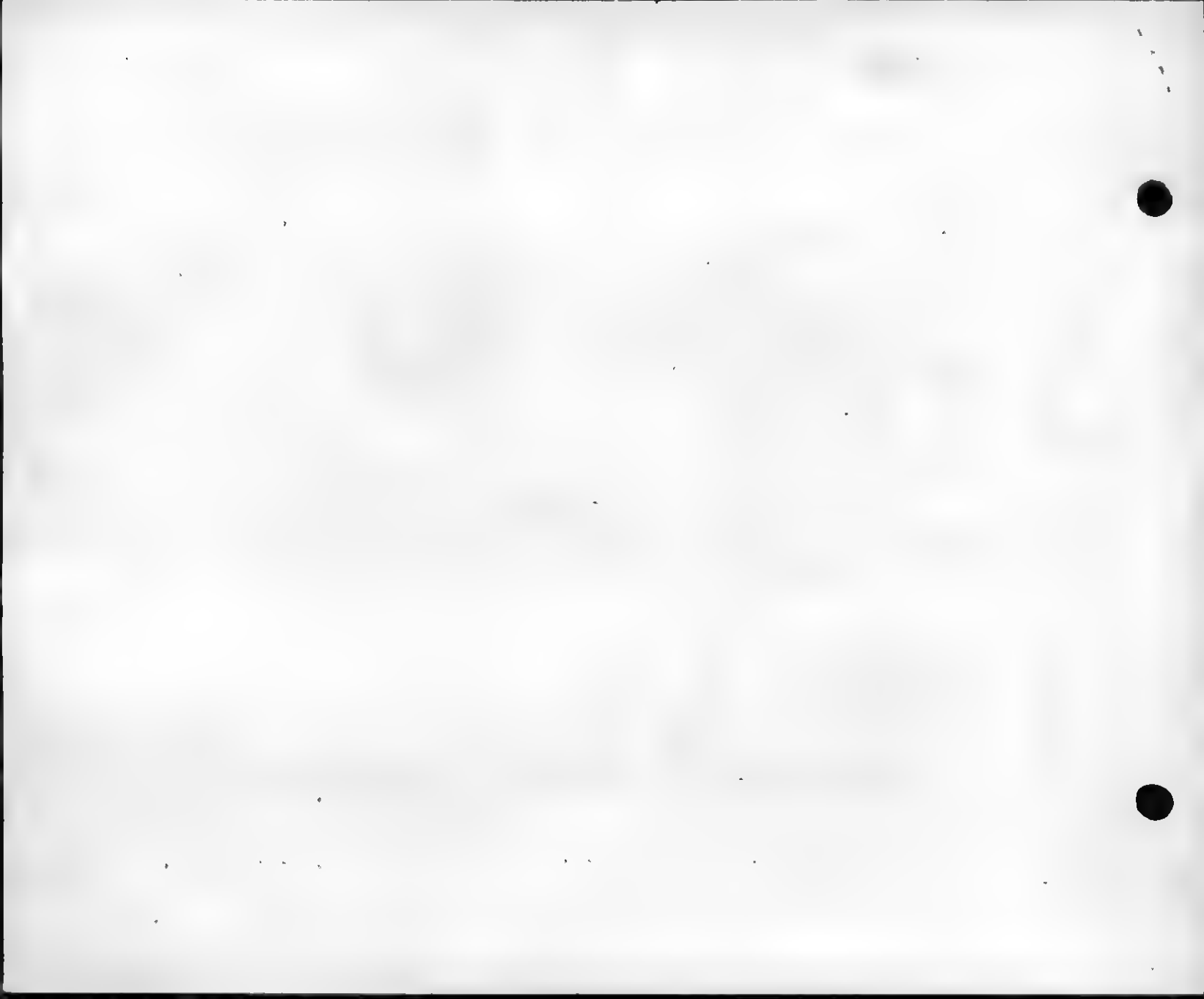
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01975

CERTIFICATE OF DEATH

01971

1 PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 'b' 1		2 USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Maryland b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 7910 Highpoint Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Ethel		First M		Middle M		Last TYLER		4. DATE OF DEATH Month February Day 10 Year 19 67		5 SEX Female		6 COLOR OR RACE W	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 15, 1895		9 AGE (n years last birthday) 71 yrs		F UNDER 1 YEAR Months 7		DAYS 10		HOURS 10		MIN. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY *****		11 BIRTHPLACE (County & State, or foreign country) New Jersey		12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William J. Hopper		14. MOTHER'S MAIDEN NAME Louisa James		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No *****	
16. SOCIAL SECURITY NO 217-09-8196		17 INFORMANT Family records		Address		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. 331X Cerebro-vascular accident (most probably Hemorrhage) IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/10/ , 19 67 , to 2/10/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/10/ , 19 67 , and that death occurred at 3:30 M, from causes and on the date stated above		22a SIGNATURE Joel V. Tolentino		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED 2-10-67		22c PHYSICIAN'S NAME (Type) Joel V. Tolentino, M.D.		22d ADDRESS 7620 York Rd., Towson, Md. 21204		23a BURIAL, CREMATION, or other disposal Burial	
23b DATE THEREOF 2/14/67		23c NAME OF CEMETERY OR CREMATORY Balto National Cem		23d LOCATION (City or Town) (County) (State) Balto Md.		24. FUNERAL DIRECTOR C.FEVANS & SON 8802 Harford road		25a REC'D BY REGISTRAR DATE FEB 14 1967		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (A)
20 M 1 65

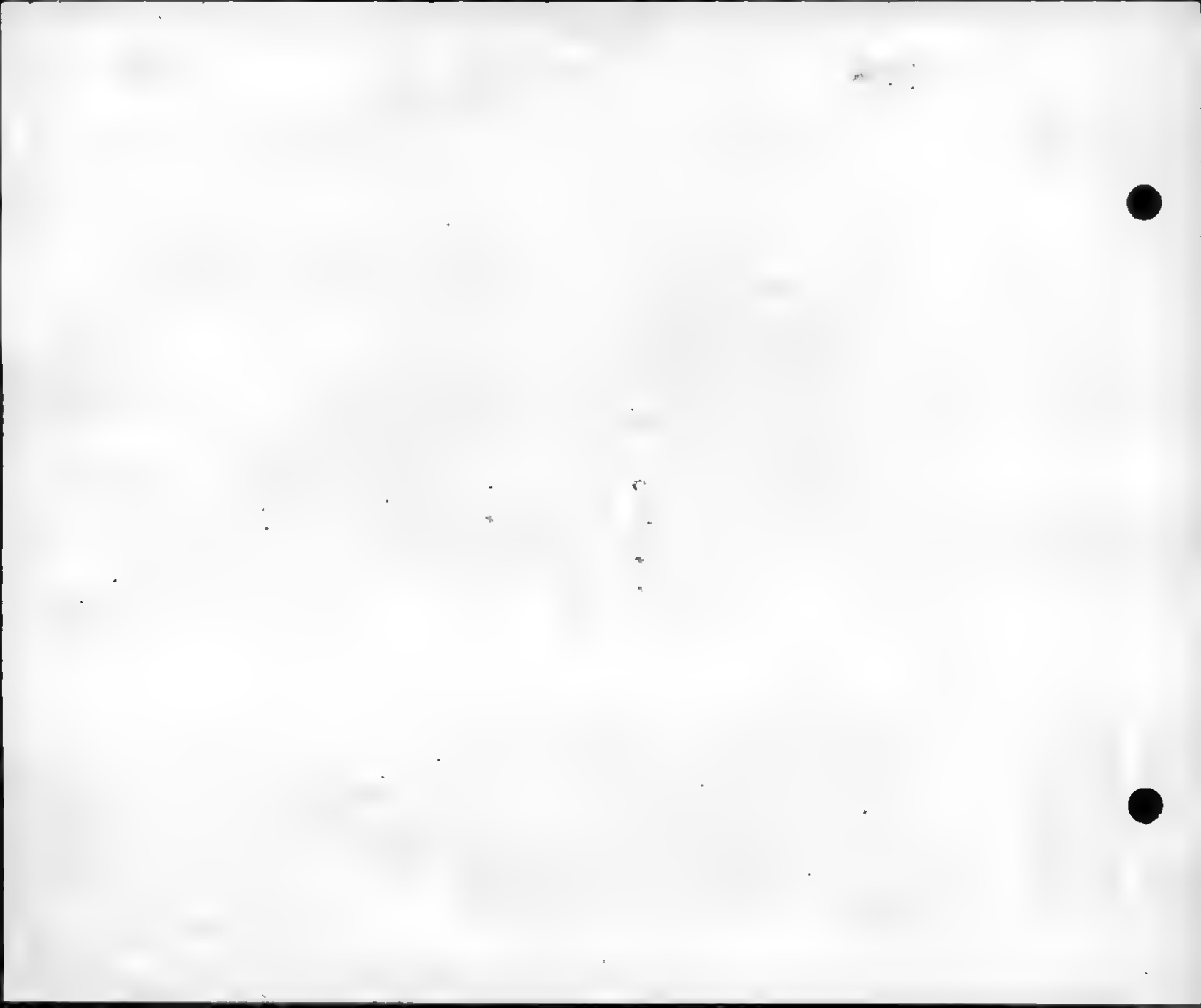
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01976

CERTIFICATE OF DEATH

01972

1 PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT COMM. HOME</u>		d. STREET ADDRESS <u>26 NEWBURG AVE.</u>	
3 NAME OF DECEASED (Type or print) <u>GENEVIEVE L. UPMAN</u>		4. DATE OF DEATH <u>FEB. 27</u> 19 <u>67</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/16/80</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. F UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEC.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN B. UPMAN</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN M. PATTERSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213031885</u>	
17. INFORMANT <u>PAUL KAEHLER</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SOX</u> DUE TO <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Subarachnoid Hemorrhage</u> (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>4 weeks</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/31/67</u> , to <u>19</u> , that (I) <u>live</u> saw the deceased alive on <u>2/26/67</u> , and that death occurred at <u>6:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W E McGrath</u>		22b. DATE SIGNED <u>2/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W E McGrath M.D.</u>		22d. ADDRESS <u>1303 Frederick Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>3/12/67</u>	<u>CATHEDRAL</u>	<u>BALTO. MD.</u>
24. FUNERAL DIRECTOR <u>E. S. MACNABB</u>		25a. REC'D BY REGISTRAR <u>301 FREDERICK RD</u> <u>21278</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 3</u> 19 <u>67</u>	

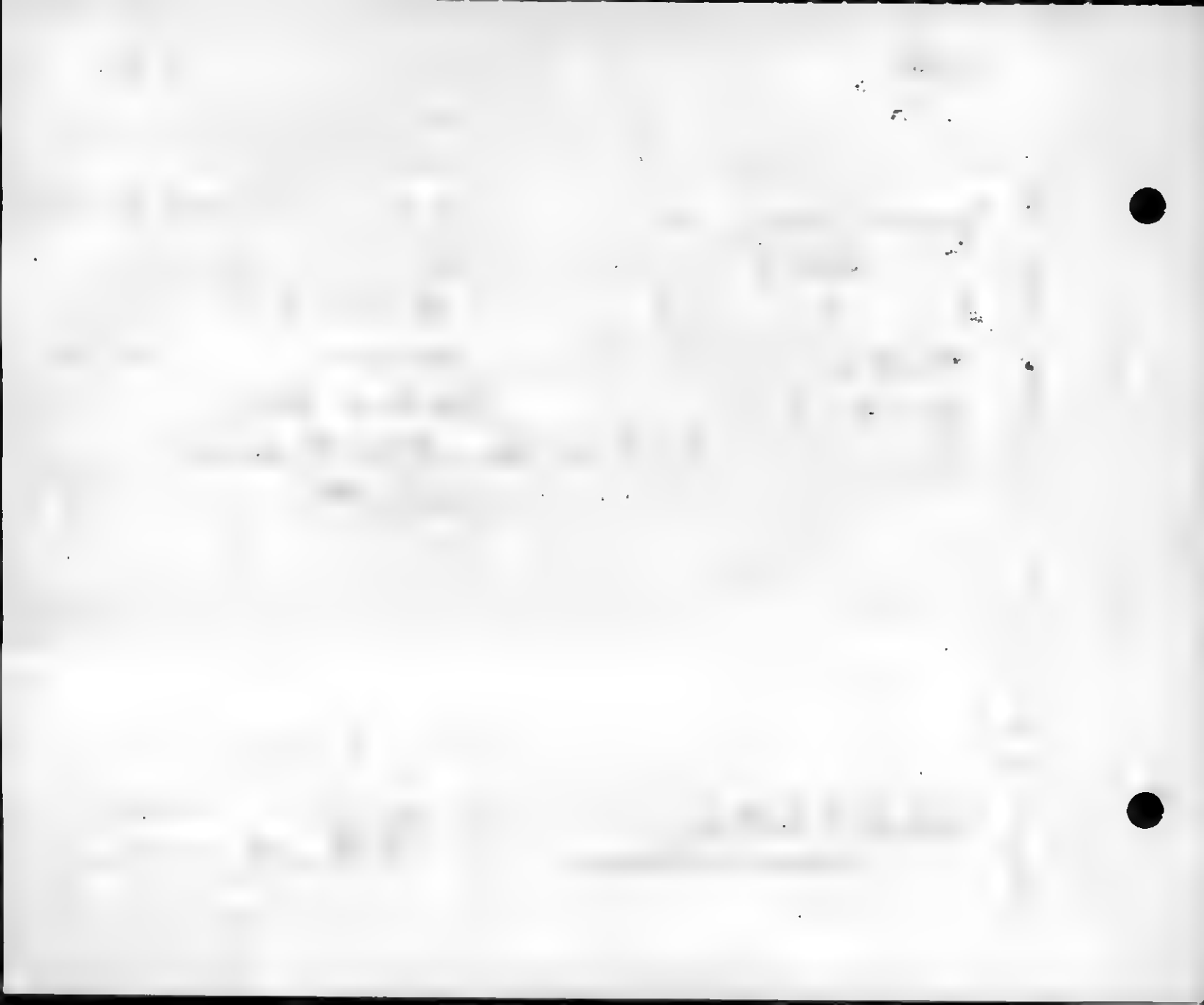


TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Approved by phone with J. P. P. Coffey, Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01977				CERTIFICATE OF DEATH				01973			
1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>				c. LENGTH OF STAY IN 1b <u>6 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foxleigh Nursing Home</u>						d. STREET ADDRESS <u>3531 Milvale Rd. Balto. 7</u>					
3. NAME OF DECEASED (Type or print) <u>Ussery, Genevieve</u> ^{LAST FIRST MIDDLE-INITIAL}						4. DATE OF DEATH <u>Feb. 2 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-24-78</u>		9. AGE (in years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ward, G. D.</u>						14. MOTHER'S MAIDEN NAME <u>MacKew, Laura</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-48-6626</u>		17. INFORMANT Address <u>Mr. Thomas O. Wonnell</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD - decompensated</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2 Feb</u> , 1967, to <u>2 Feb</u> , 1967, that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>19</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles H. Williams</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2 Feb 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>						22d. ADDRESS <u>Pikesville 21208, Md.</u>					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>Feb. 4, 1967</u>		<u>Forest Ridge Cemetery</u>				<u>Pikesville 8, Md.</u>			
24. FUNERAL DIRECTOR <u>Lowell Funeral Home</u>						25a. REC'D BY REGISTRAR <u>Feb 6</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 12 Film 6306

01974

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)

Baltimore 7

c. LENGTH OF STAY (in days)

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

a. STATE

Md.

b. COUNTY

Baltimore

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Baltimore 7

d. STREET ADDRESS

3806 Sylvan Drive

IS RESIDENCE ON A FARM?

YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

Edith E. Vaughan

4. DATE OF DEATH

Feb. 15

19 67

5. SEX

F

6. COLOR OR RACE

Cauc.

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

Jan. 15, 1888

9. AGE (In years last birthday)

79

10. IF UNDER 1 YEAR IF UNDER 24 HRS

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Late - Harry Wadkin

14. MOTHER'S MAIDEN NAME

Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

219-30-7312

16. SOCIAL SECURITY NO

Mr. Robert E. Vaughan

17. INFORMANT Address

108 Ligon Rd. - Ellicott City, Md. - 21043

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO

arteriosclerotic C.V. Disease
Cerebral arteriosclerosis
Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

4 yrs
4 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Inter Trochanteric Fracture Left Hip - Pinned at mass.

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

Fell at home.

20c. TIME OF INJURY

Hour a.m. 10-9 p.m. 1966

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

Clinton

(County)

(State)

Mass

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street city town, or county)

DATE SIGNED

2-16-67

ACTUAL SIGNATURE

D. D. Caples

EXAMINER'S NAME (Type)

D. D. CAPLES

22a. BURIAL, CREMATION REMOVAL (Specify)

Burial

22b. DATE THEREOF

2-18-67

22c. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cem.

22d. LOCATION (City town, or country)

Baltimore, Md.

(State)

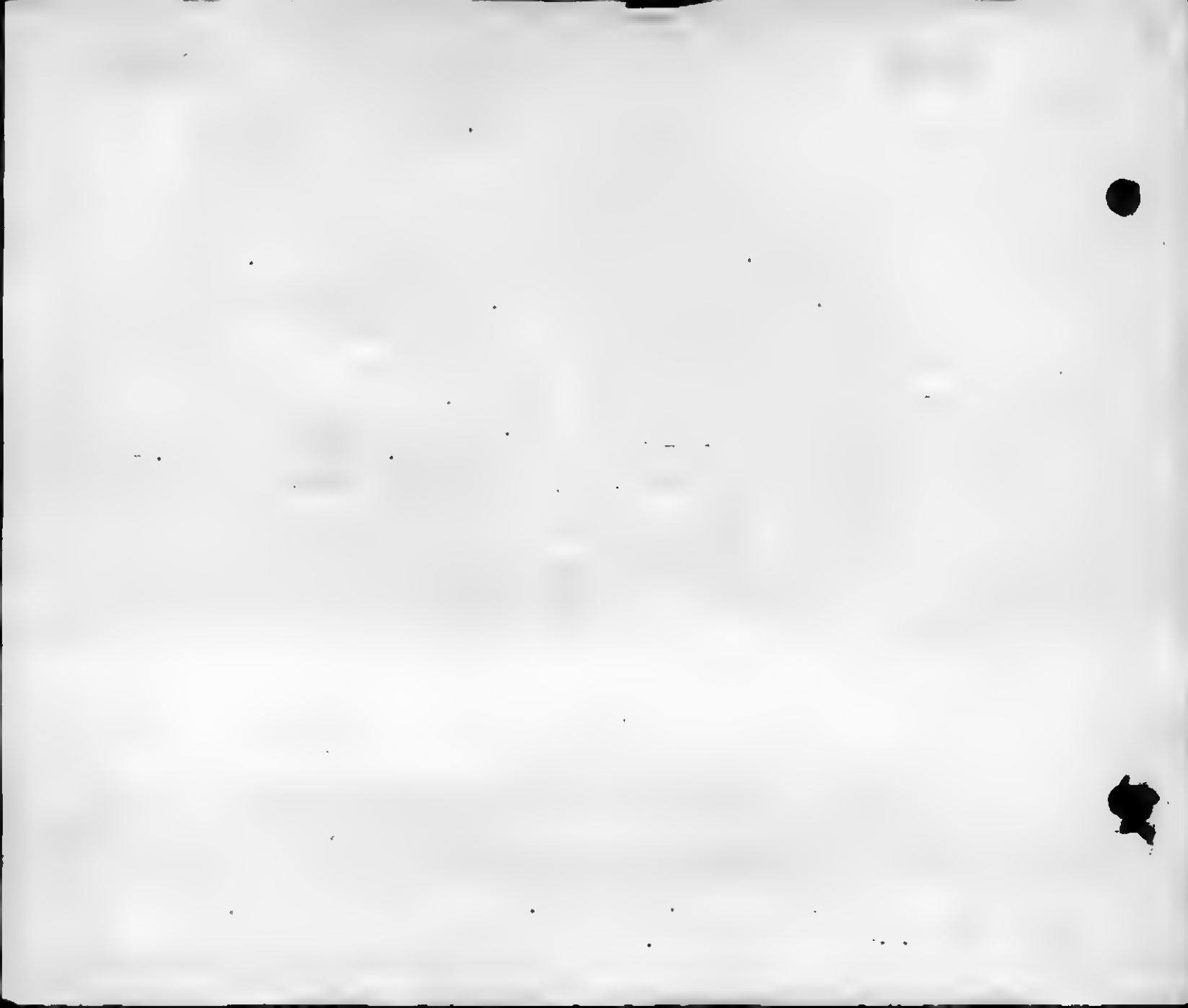
23. FUNERAL DIRECTOR

Witzke F.D.-4101 Edmondson Ave.

24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

DATE FEB 20 1967

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

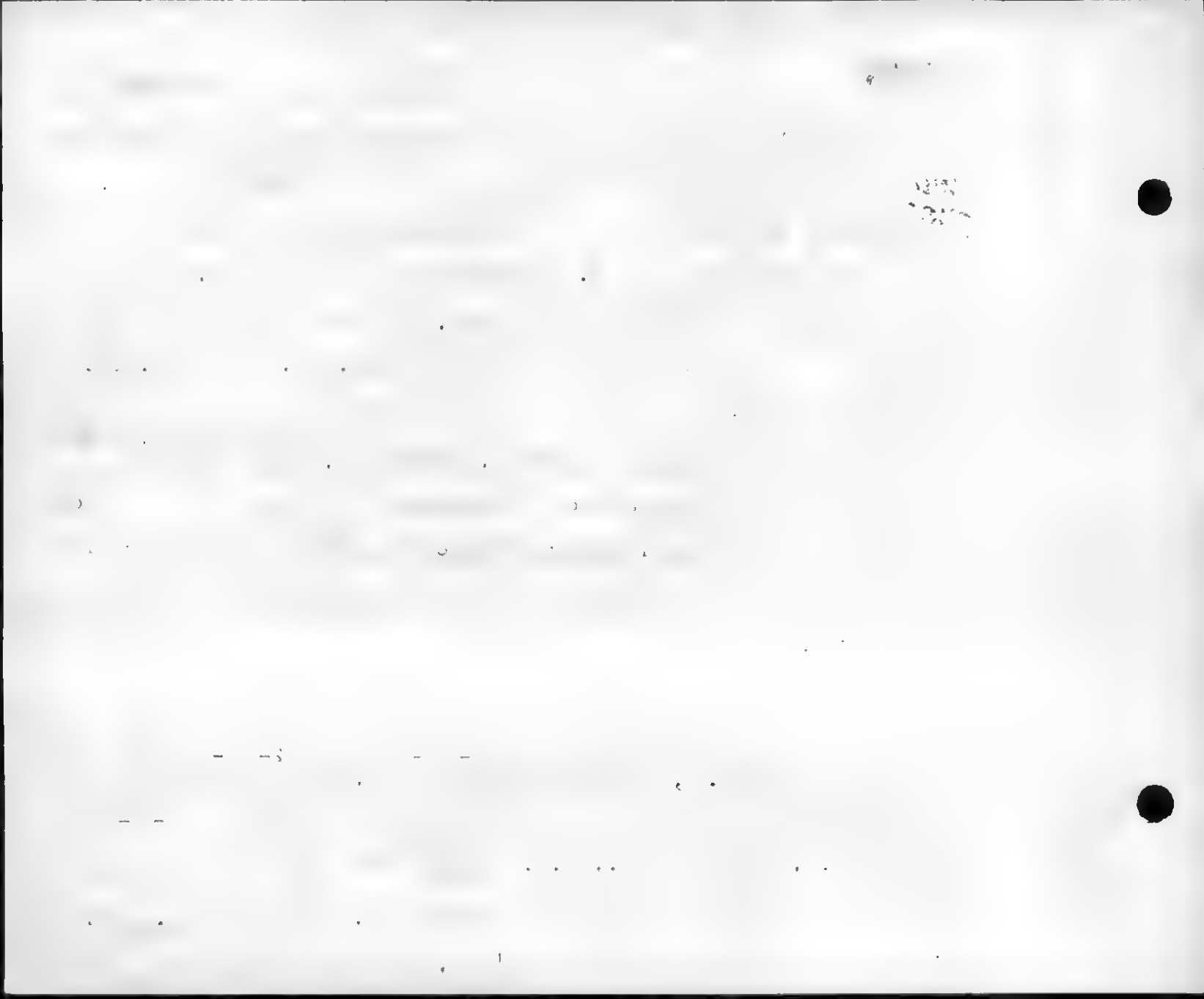
01979

CERTIFICATE OF DEATH

01975

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Baltimore			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234			c LENGTH OF STAY IN 'b 8 years		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8305 Ridgely Oak Road				d. STREET ADDRESS 8305 Ridgely Oak Road		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard G. von Karstedt				4 DATE OF DEATH Month Feb. Day 8 Year 1967			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Sept. 3, 1905	
9 AGE (n years last birthday) 61 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY Radio		11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.				13 FATHER'S NAME Bernard von Karstedt			
14 MOTHER'S MAIDEN NAME Alice King				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16 SOCIAL SECURITY NO. 215-10-8913				17. INFORMANT Mrs. Bernard G. von Karstedt			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypernephroma (carcinoma) kidney DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 mos			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-24-1965 , to 2-8-1967 , that (I) (we) last saw the deceased alive on Feb. 6, 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above.							
22a SIGNATURE <i>S.J. Venable, Jr.</i> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED 2-10-67	
22c. PHYSICIAN'S NAME (Type) S.J. Venable, Jr., M.D.				22d. ADDRESS 7215 York Road			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 2/11/67		23c NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk. Baltimore Co., Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>William E. Jones</i>				25a REC'D BY REGISTRAR 5521 Loch Raven B'ld.		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

DATE **FEB 14 1967**



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

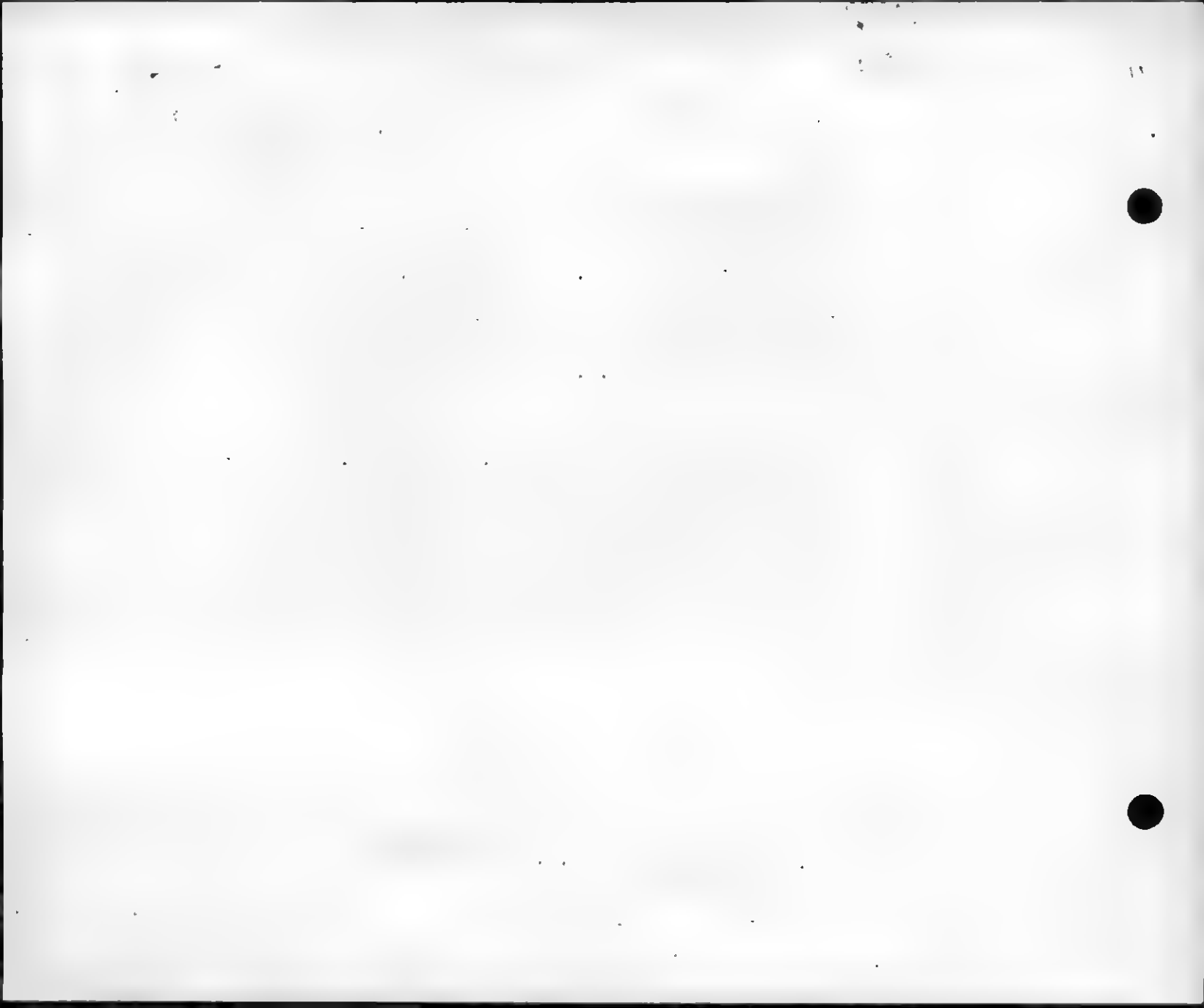
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01980

CERTIFICATE OF DEATH

01976

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Md. b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c LENGTH OF STAY in 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 154 Clyde Avenue 21227		d STREET ADDRESS 154 Clyde Avenue 21227	
3 NAME OF DECEASED (Type or print) First Elmer Middle E. Last Wain, Sr.		4 DATE OF DEATH Month Feb. Day 14 Year 1967	
5 SEX Male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 10-13-80
9 AGE (In years lost birthday) yrs 86		10 UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY B & O R.R.	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME George Wain		14 MOTHER'S MAIDEN NAME Emity Rumney	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Mrs. Gertrude E. Crivelli-154 Clyde Ave		Address 21227	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured Abdominal Aortic Aneurysm 401X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Feb. 12, 1967 to Feb. 14, 1967 , that (I) (we) last saw the deceased alive on Feb. 12, 1967 , and that death occurred at 11:30 AM , from causes and on the date stated above.			
22a SIGNATURE C. Arthur Rossberg, M.D. M.D.		22b DATE SIGNED 2/15/67	
22c PHYSICIAN'S NAME (Type) C. Arthur Rossberg, M.D.		22d ADDRESS 2436 Washington Blvd. 21230	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 2-17-67	23c NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d LOCATION (City or town) (County) (State) 2930 Frederick Rd. Balto, Md.
24. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Avenue 21229		25a REC'D BY REGISTRAR EEB 17 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

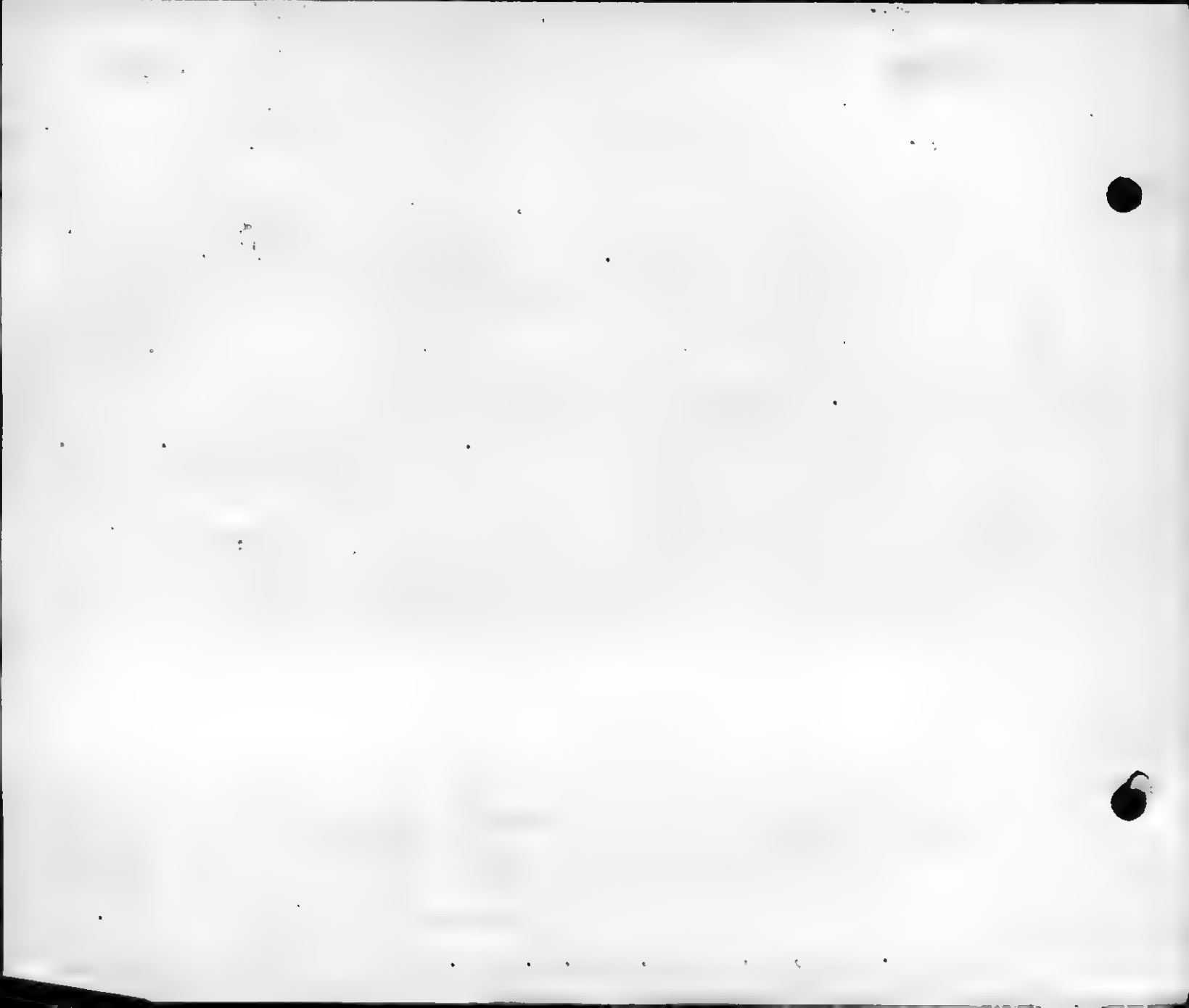
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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01984

01977

1 PLACE OF DEATH - a. COUNTY <i>Baltimore</i> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>872</i> OR INSTITUTION <i>Armcoast Nursing Home Regester Ave. Rodgers Forge Ave.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <i>Alma T. Walker</i>				4. DATE OF DEATH Month Day Year <i>February 24 1967</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 4, 1890</i>	
9. AGE (In years lost birthday) yrs <i>76</i>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Norbourn A. Thomas</i>				14. MOTHER'S MAIDEN NAME <i>Rose Fullenkamp</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO <i>none</i>		17. INFORMANT Address <i>Henry M. Walker 2610 Whitney Ave. Balto.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Recurrent cerebral vascular occlusion</i> DUE TO (b) <i>Cerebrovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2 hrs</i> <i>8 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 1956</i> to <i>Feb 24, 1967</i> that (I) (we) last saw the deceased alive on <i>Feb 24, 1967</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Frederick J. Vollmer</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>2-24-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>FREDERICK J. VOLLMER</i>				22d. ADDRESS <i>6100 YORK RD, BALTIMORE, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/27/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Mount Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran, Inc.</i>				25a. REC'D BY REGISTRAR <i>Feb 27 1967</i>		25b. REGISTRAR'S SIGNATURE <i>John A. Moran, Inc.</i>	



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01982

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01978

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (where deceased lived, if institution residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b -	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Reisterstown Rd. & Pleasant Hill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Charles E. Warren		4 DATE OF DEATH Month Feb. Day 12, Year 19 67	
5 SEX Male		6. COLOR OR RACE White	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 27, 1906	
9 AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS Hours 0 Min 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY -	
11 BIRTHPLACE (State or foreign country) Balto. Co. Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James H. Warren		14 MOTHER'S MAIDEN NAME Nora C. Townsend	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 213-03-4803	
17 INFORMANT Mr. Charles E. Warren Jr.		Address Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Compound fractures both legs, middle third; DUE TO Fractured left femur; fractured cervical vertebra; fractured skull. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 min. est.		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pedestrian crossing Reist. Rd. & struck by automobile	
20c. TIME OF INJURY Month, Day Year 6:37 p.m. Feb. 12, 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) Reist. Rd.		20f. (City or town) (County) (State) Owings Mills Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		22. DATE SIGNED 2-14-67	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		6 Hanover Rd. Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/67	
23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill		23d. LOCATION (City or Town) (County) (State) Owings Mills, Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons		ADDRESS Reisterstown, Md.	
25a. REC'D BY REGISTRAR FEB 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01983

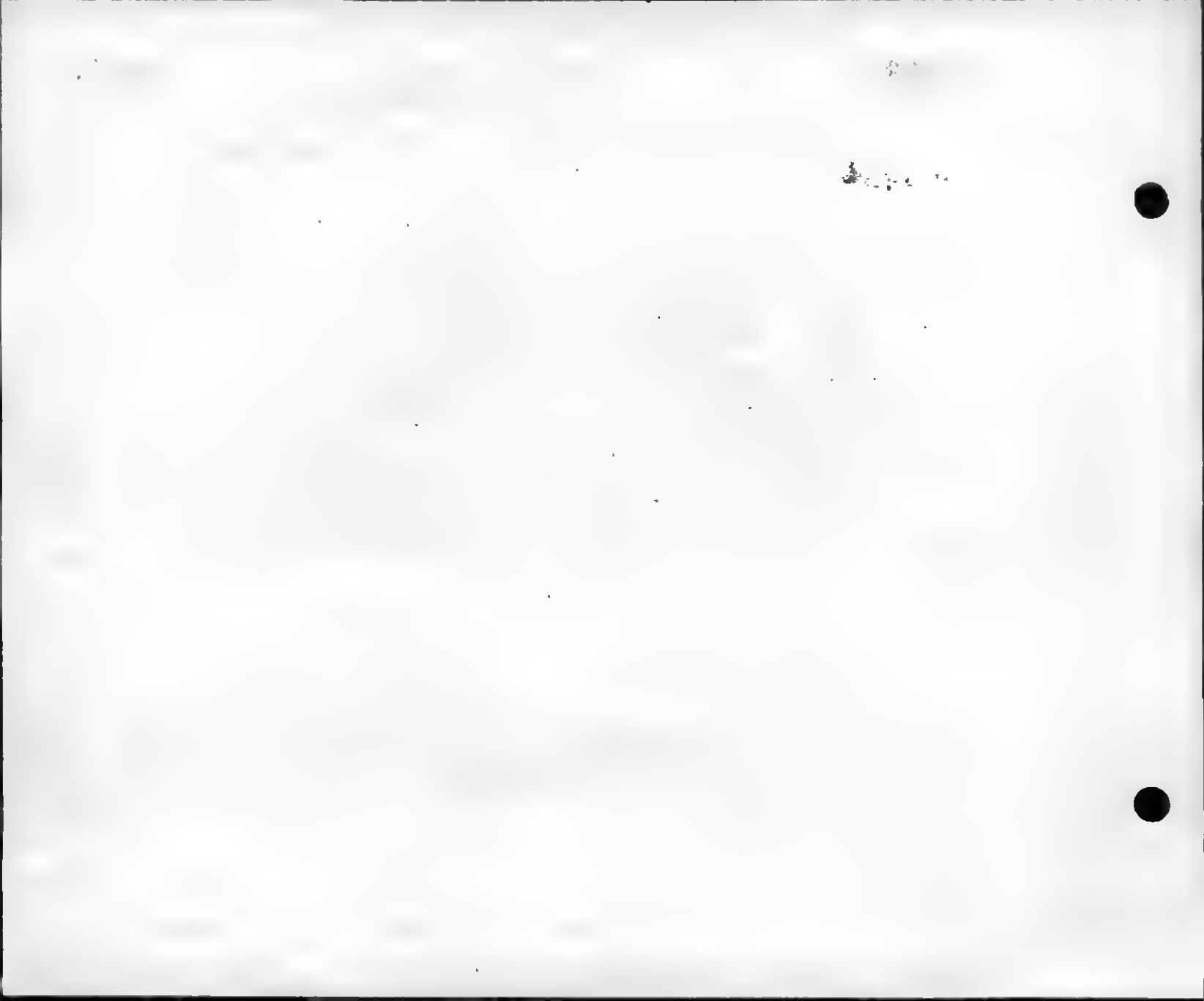
CERTIFICATE OF DEATH

01979

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>		d. STREET ADDRESS <u>108 Pleasant Hill Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>SPRING GROVE STATE Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>LEWIS</u> Last <u>WATSON</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-86</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MANUFACTURING Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND, Baltimore County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Joseph M. Watson</u>		14. MOTHER'S MAIDEN NAME <u>Agnes E. Moran</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>212-10-7235</u>	
17. INFORMANT <u>JANET FADLEY - Daughter - Owings Mills, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARTION</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO <u> </u> (c) <u>DIABETES MELLITUS</u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>1-19</u> , 19 <u>67</u> , to <u>2-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> , 19 <u>67</u> , and that death occurred at <u>9:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Rolando Vieta</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO VIETA</u>		22d. ADDRESS <u>SPRING GROVE ST. HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Finksburg, Carroll, Md.</u>
24. FUNERAL DIRECTOR <u>H. J. Eckhardt</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 7 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

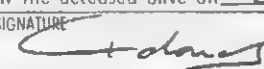
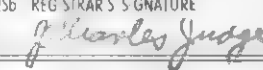


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

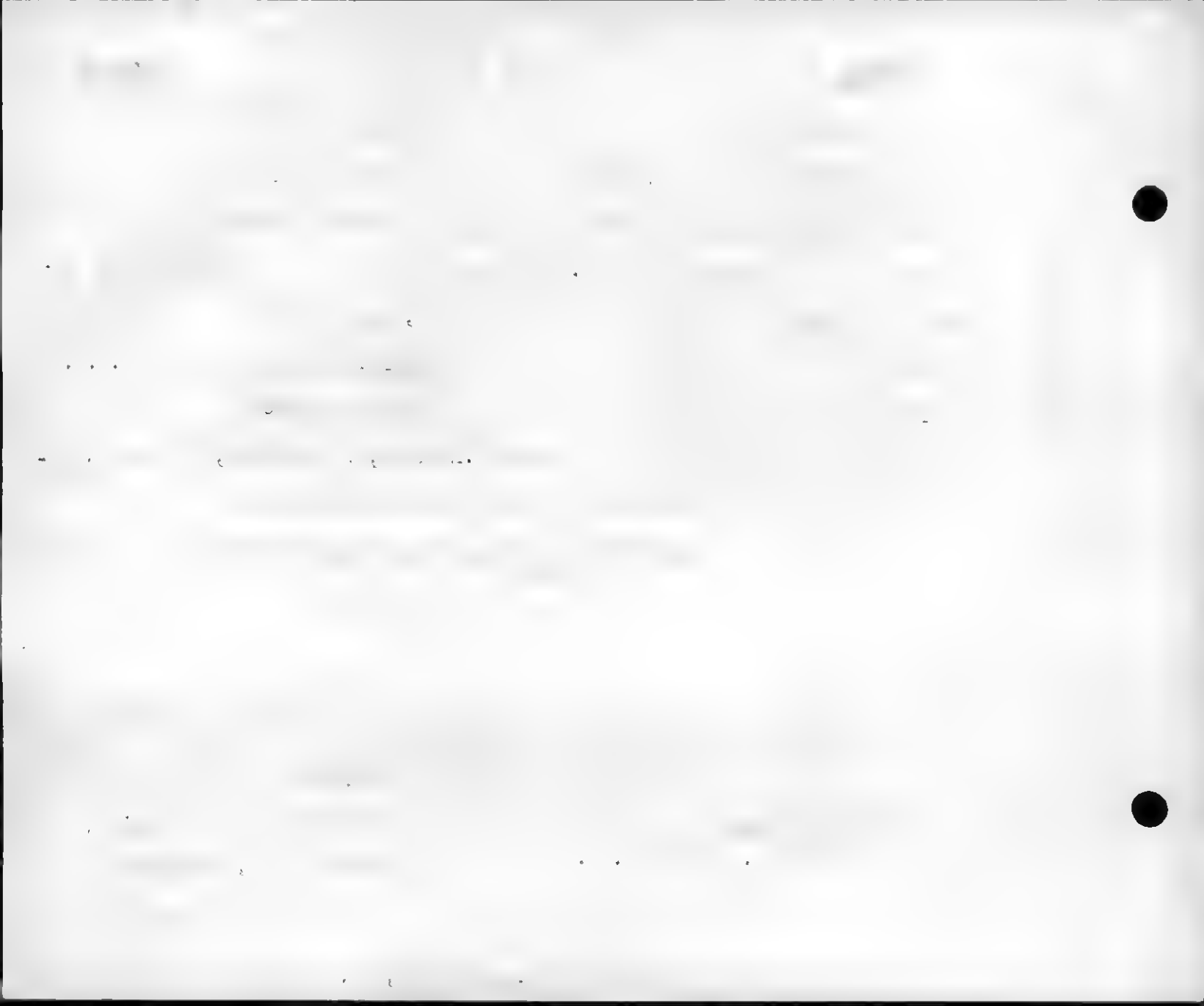
01984

CERTIFICATE OF DEATH

01980

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT HOWARD			c. LENGTH OF STAY IN 1b 18 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 21205			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1041 MC DONOUGH STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle L. Last WEBSTER				4. DATE OF DEATH Month FEBRUARY Day 14 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17, 1907		9. AGE (in years last birthday) yrs 59	F UNDER 1 YEAR Months _____ Days _____	F UNDER 24 HRS Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WOODRUFF, SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME ANNIE MN: UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW II		16. SOCIAL SECURITY NO 217 09 28 44		7. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS OF LEFT MIDDLE CEREBRAL ARTERY 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from 1/27/67 , 19____, to 2/14/67 , 19____, that (b) (we) last saw the deceased alive on 2/14/67 , 19____, and that death occurred 10:00AM , from causes and on the date stated above							
22a. SIGNATURE 				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/14/67	
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-20-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR Phoy O. Wilson		ADDRESS ORLEANS ST. BALTIMORE, MD.		25a. REC'D BY REGISTRAR FEB 20 1967		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/66

FOR STATE
HEALTH DEPT.

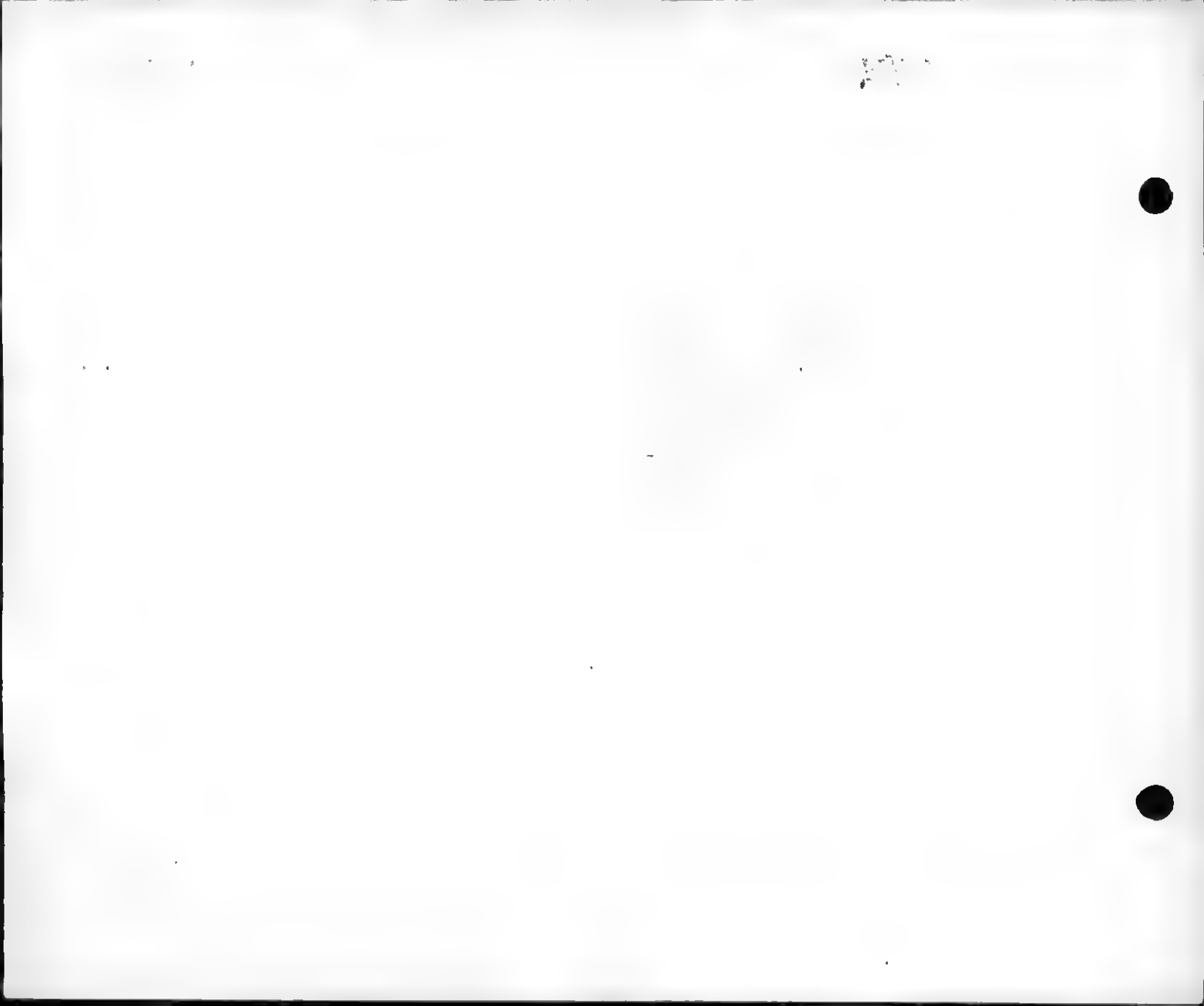
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01985

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01981

1 PLACE OF DEATH a COUNTY BALTIMORE b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) MIDDLE RIVER c LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY BALTIMORE c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) ARBUTUS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GLEN L. MARTIN CO.		d STREET ADDRESS 5823 OAKLAND RD.	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Harold Middle R. Last White		4 DATE OF DEATH Month FEBRUARY Day 7 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-16-1913
9 AGE (In years last birthday) 53 yrs		IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min 53	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Foreman		10b KIND OF BUSINESS OR INDUSTRY Martin Co.	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZENSHIP OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME William A. White		14 MOTHER'S MAIDEN NAME Louisa	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 212-07-5311	
17 INFORMANT ANNA WHITE Address 5823 OAKLAND RD. 21227			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO As-cvd Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) As-cvd Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH —	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Davis EXAMINER'S NAME (Type) MELVIN B. DAVIS		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 6800 MORINGTON RD.	
22. DATE SIGNED 2/7/67			
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 2-11-1967	
23c NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d LOCATED ON (City or Town) (County) (State) Howard County, Maryland	
24 FUNERAL DIRECTOR HOWARD H. HUBBARD ADDRESS 4107 WILKENS AVE. 21229		25a REC'D BY REGISTRAR FEB 10 1967 25b REGISTRAR'S SIGNATURE Charles Judge	



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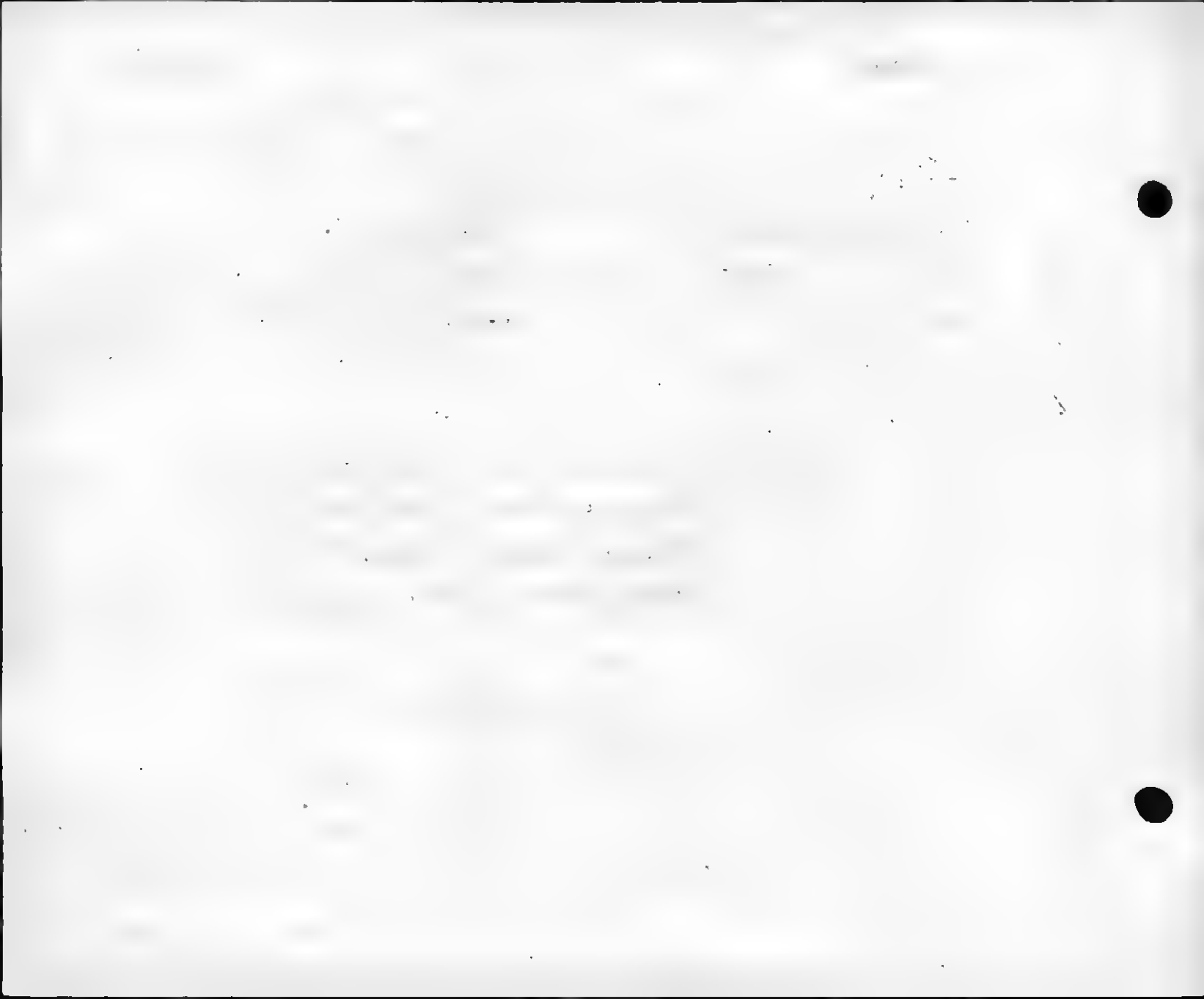
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01986

CERTIFICATE OF DEATH

01982

1 PLACE OF DEATH a COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE Maryland b COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 316 Radnor Rd.	
3 NAME OF DECEASED (Type or print) First Middle Last Harry Blackwell WHITE		4 DATE OF DEATH Month Day Year February 1, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1897
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months Days Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONVEYER MANIPULATORS		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11 BIRTHPLACE (County & State, or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Dameon B White		14. MOTHER'S MAIDEN NAME Sally Ann Bishop	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes NWI		16 SOCIAL SECURITY NO 216-09-944	
17 INFORMANT Mrs Harry White		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent carcinoma of right lung DUE TO (b) Status post left pneumonectomy (1962) DUE TO (c) Terminal bronchopneumonia.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/14/ , 19 67 , to 2/1/ , 19 67 , that (I) (we) last saw the deceased alive on 2/1/ , 19 67 , and that death occurred at 12:30M , from causes and on the date stated above.			
22a. SIGNATURE Fiorello G. Malit		22b. DATE SIGNED February 1, 1967	
22c. PHYSICIAN'S NAME (Type) Fiorello G. Malit, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2-4-67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d. LOCATION (City or town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR CHAS. F. EVANS		25a. REC'D BY REGISTRAR 8802 Hartford Rd	
25b. REGISTRAR'S SIGNATURE Chas. F. Evans		DATE FEB 3 1967	



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1

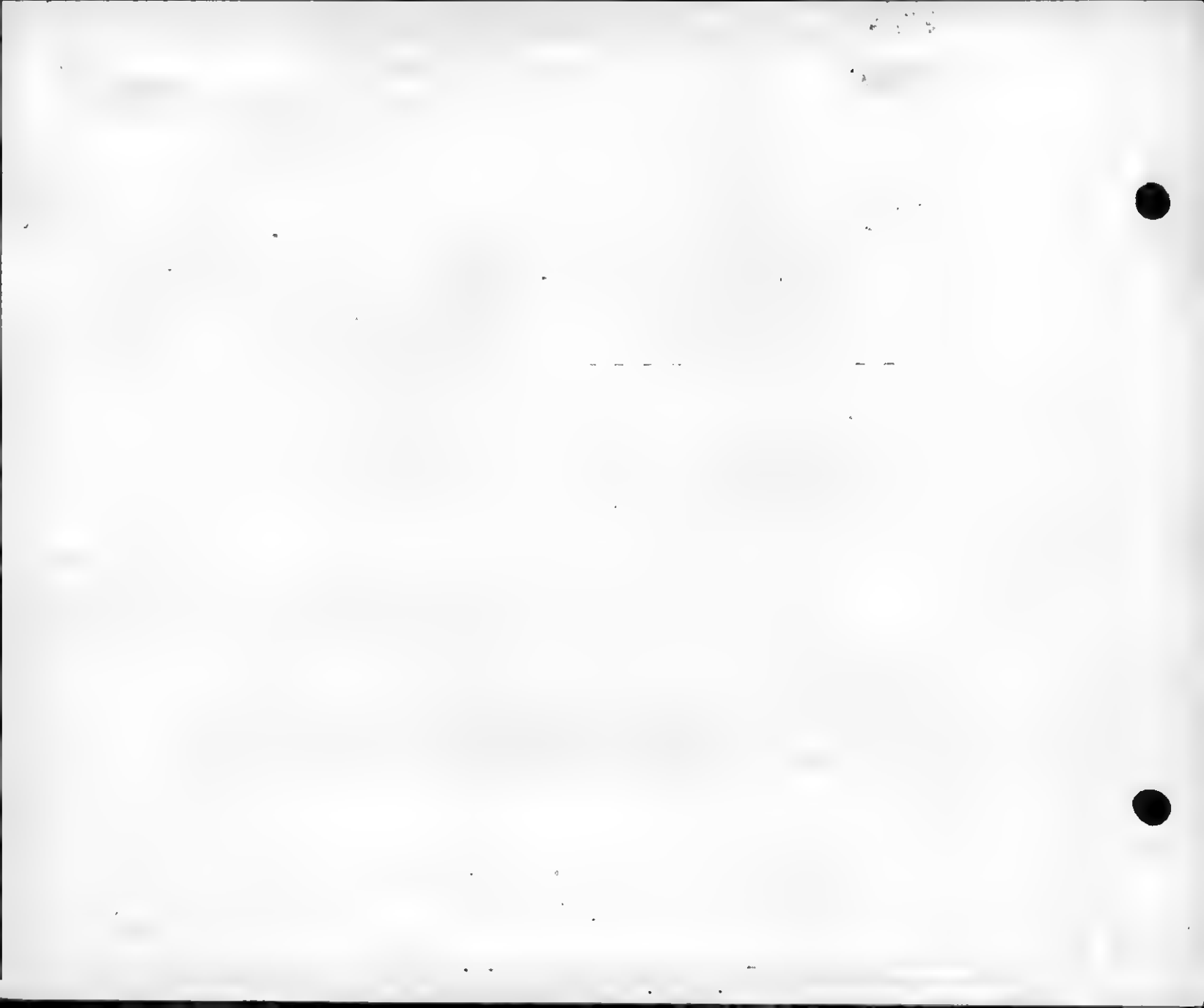
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01987

CERTIFICATE OF DEATH

01987

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u>		c LENGTH OF STAY IN 1b <u>21-1</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp't, give street address) <u>St. Josephs Hospital</u>		d STREET ADDRESS <u>4312 Woodlea Ave.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Theodore William WHITE</u>		4 DATE OF DEATH Month Day Year <u>February 13 19 67</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>February 12, 1967</u> AGE (In years last birthday) yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>
13. FATHER'S NAME <u>Richard A. White</u>		14. MOTHER'S MAIDEN NAME <u>June A. Edwards</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	17. INFORMANT <u>HOSP. RECORDS</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>(A)</u> (this hospital) attended the deceased from <u>February 12 19 67</u> , to <u>February 13 19 67</u> that <u>(A)</u> (we) last saw the deceased alive on <u>February 13 19 67</u> , and that death occurred at <u>2:15M</u> from causes and on the date stated above.			
22a SIGNATURE <u>Lawrence F. Misnik</u>		22b DATE SIGNED <u>February 13, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence F. Misnik, M.D.</u>		22d. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>	
23a BURIAL, CREMATION, REMOVAL, ETC. <u>Burial</u>	23b DATE THEREOF <u>2/21/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

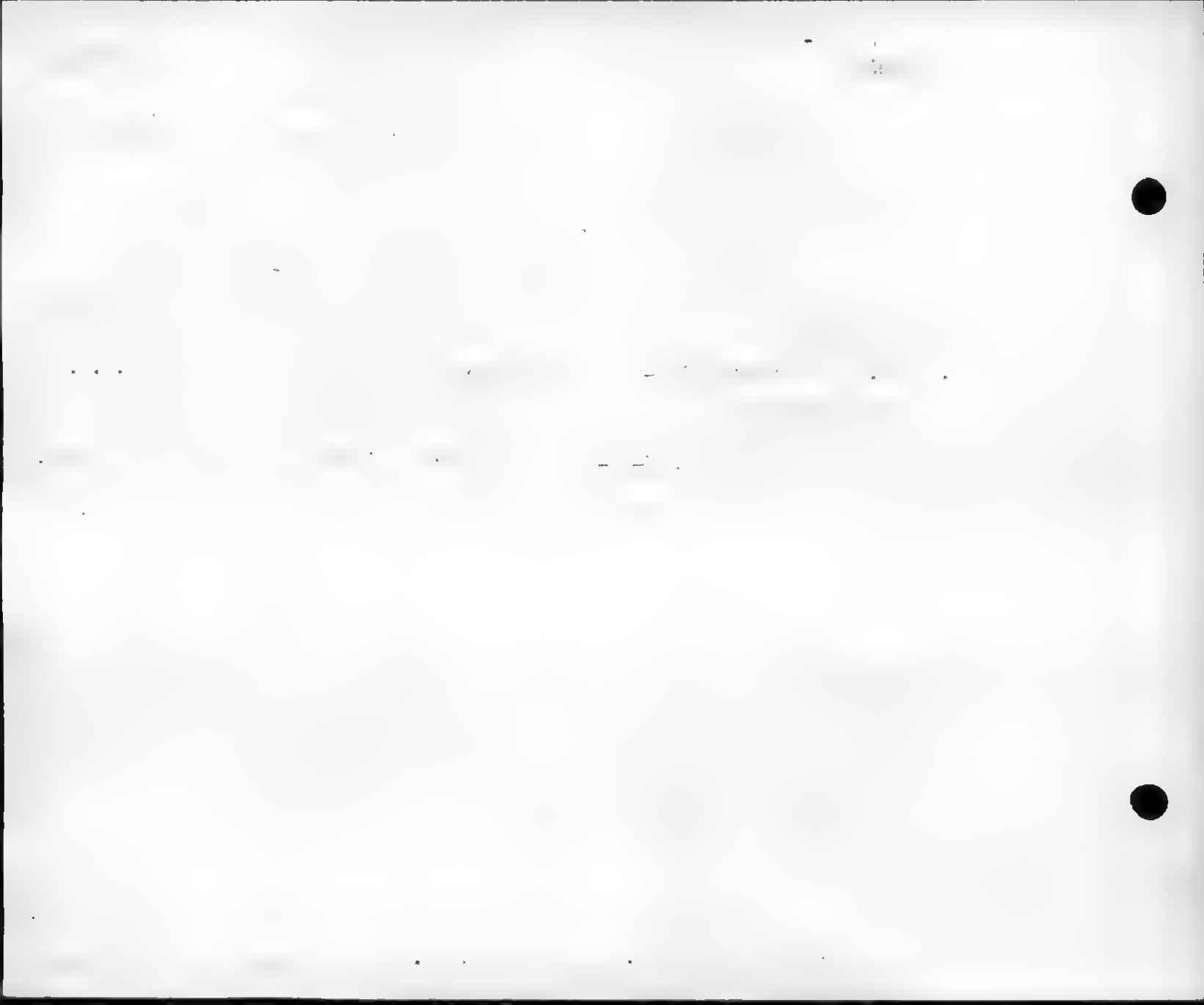
01988

01984

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>BALTO.</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c LENGTH OF STAY IN b			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ST. JOSEPH'S HOSPITAL</u>				e STREET ADDRESS <u>5707 CHINQUAPIN PKWY</u>			
3 NAME OF DECEASED (Type or print) <u>FRANK L. WIELAND</u>				4 DATE OF DEATH <u>FEB. 21 1967</u>			
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/6/94</u>	9 AGE (In years last birthday) <u>72</u> Yrs	10 UNDER 1 YEAR Months Days Hours Min		11 UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Supv. of Transportation - Gunthers Brewery Baltimore</u>				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13 FATHER'S NAME <u>John Wieland</u>				14 MOTHER'S MAIDEN NAME <u>Pauline Wells</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16 SOCIAL SECURITY NO <u>215-01-9453</u>		17 INFORMANT <u>Marguerite Wieland 5707 Chinquapin Pkwy.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>and Tachycardia</u> (b) <u>and Tachycardia</u> (c) <u>and Tachycardia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):						19 WA. AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work or work		20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	
				20f (city or town) (County) (State)			
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.				22 DATE SIGNED <u>2/21/67</u>			
EXAMINER'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u>				23a LOCALITY (city or town) (County) (State) <u>Randallstown Balto Md.</u>			
23b DATE THEREOF <u>2/25/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		23d LOCALITY (city or town) (County) (State) <u>Randallstown Balto Md.</u>		23e REC'D BY REGISTRAR	
24 FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u>				25 REG. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

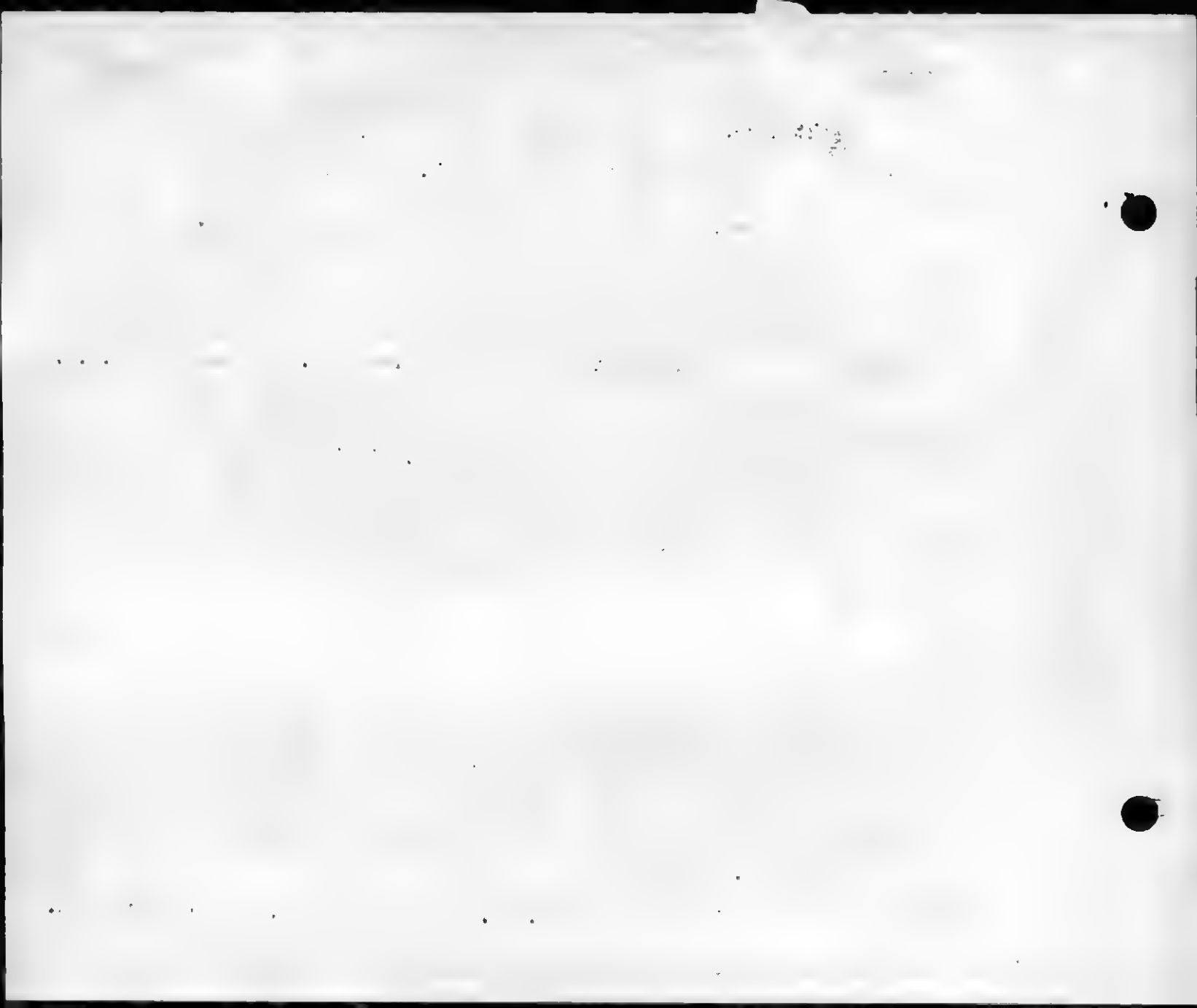
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01989

CERTIFICATE OF DEATH

01985



1. PLACE OF DEATH a. COUNTY Baltimore, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fork			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fork, Maryland 21051		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 498 Stoney Batter Road				d. STREET ADDRESS Box 498 Stoney Batter Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herman Middle Henry Last Willig			4. DATE OF DEATH Month February Day 23 Year 1967				
5 SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/30/1886		9. AGE (in years last birthday) 80 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10b. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (County & State, or foreign country) Baltimore Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Willig				14. MOTHER'S MAIDEN NAME Margaret Knox			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr John H. Willig Box 498 Stoney Batter Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH immediate
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/13, 1967 to present , 19 67 , that (I) (we) last saw the deceased alive on Feb. 7, 1967 , and that death occurred at 11:15 AM , from the causes and on the date stated above.							
22a. SIGNATURE Phyllis K. Pullen				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/23/67	
22c. PHYSICIAN'S NAME (Type) Phyllis K. Pullen				22d. ADDRESS Box 381, Route 1, Kingsville, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-1967		23c. NAME OF CEMETERY OR CREMATORY Fork Meth. Ch. Cemetery		23d. LOCATION (City, town or county) (State) Fork, Baltimore Md.	
24. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Road				25a. REC'D BY REGISTRAR 36		25b. REGISTRAR'S SIGNATURE Charles J. Juge	



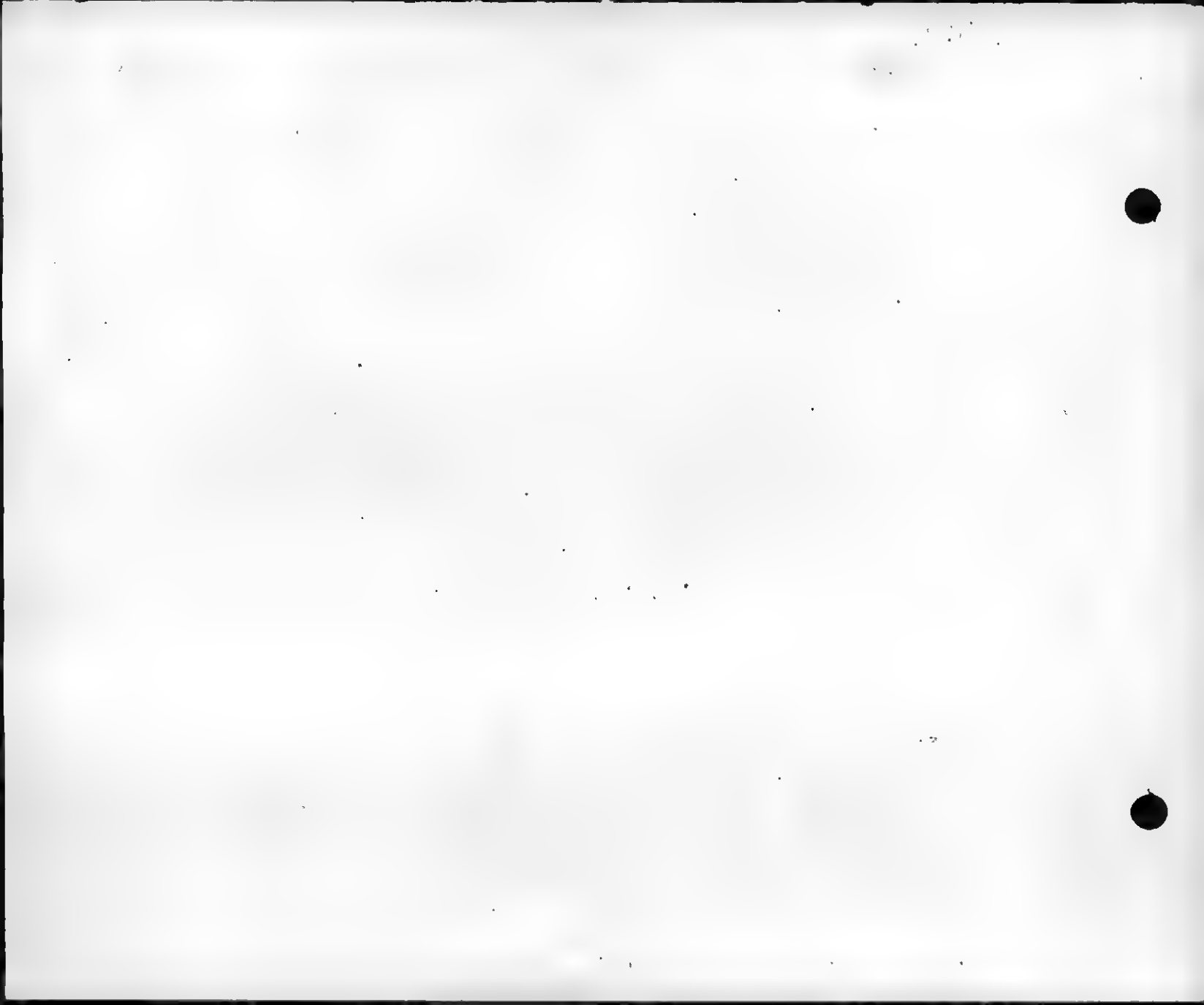
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
01990		Item 9 Film 6389 2/8/67				01986							
1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EBMC Hospital		c. LENGTH OF STAY IN lb 48 Days		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TIMONIUM, Md. 21093			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE Medical Center						d. STREET ADDRESS 241 EAST TIMONIUM ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marie		First		Middle ANNA		Last WILMOT		4. DATE OF DEATH Month 2 Day 1 Year 1967					
5. SEX Female		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-29-86		9. AGE (in years last birthday) 80 1/4 yrs.		IF UNDER 1 YEAR Months Days 0:35 P.M.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, PENN			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME George Richard Zimmerman						14. MOTHER'S MAIDEN NAME HARRIET LOWERY							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 24-30-0835-11		17. INFORMANT		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory failure 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) lymphosarcoma												INTERVAL BETWEEN ONSET AND DEATH 4	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour 4:35 a.m. p.m. 1967				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.													
22a. SIGNATURE 						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Charles J. Jones						22d. ADDRESS 2-1-67							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SAT 2/4/67		23c. NAME OF CEMETERY OR CREMATORY Great Valley Presby Cem.				23d. LOCATION (City, town or county) (State) MAVERNA R.D. Chester, PA.					
24. FUNERAL DIRECTOR Wm. Cook Brooks Inc. 57 PAUL I. PRESTON				25a. REC'D BY REGISTRAR FEB 6 1967		25b. REGISTRAR'S SIGNATURE 							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

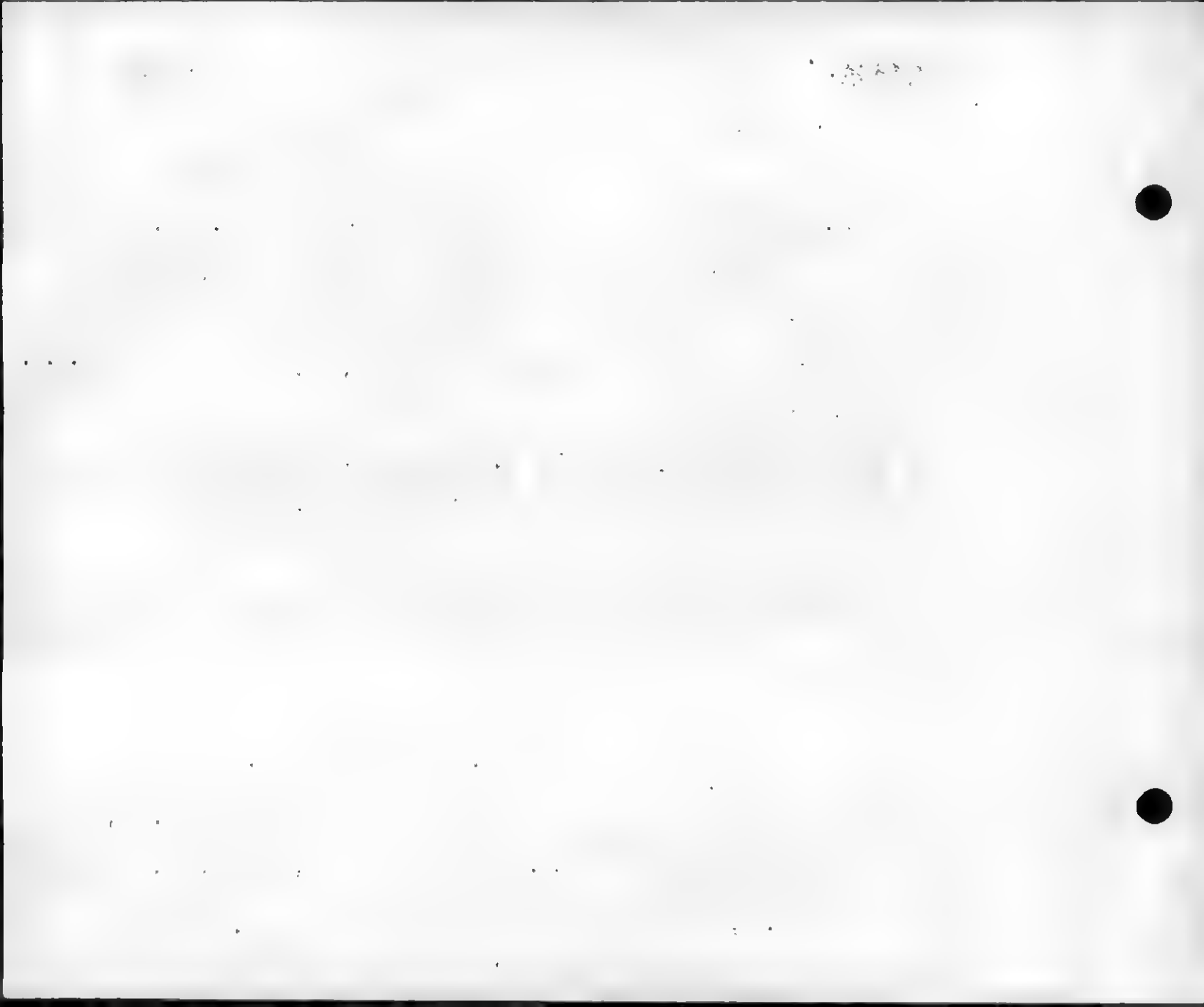
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01991

CERTIFICATE OF DEATH

01987

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212	
f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		g. STREET ADDRESS 116 Dumbarton Rd. Apt. D	
3. NAME OF DECEASED (Type or print) First Middle Last Edward Nicholas Witler		4. DATE OF DEATH Month Day Year Feb. 27 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-99
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Insurance Broker	
11. BIRTHPLACE (County & State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Nicholas Witler		14. MOTHER'S MAIDEN NAME Emma Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216 01 0641 A	
17. INFORMANT M. Agnes Witler		Address 116 Dumbarton Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease -myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of colon			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 25 1967 to Feb. 27 1967 , that (I) (we) last saw the deceased alive on Feb. 27 1967 , and that death occurred at 5:35 AM , from causes and on the date stated above			
22a. SIGNATURE Melencio Ventura		22b. DATE SIGNED Feb. 27, 1967	
22c. PHYSICIAN'S NAME (Type) Melencio Ventura M.D.		22d. ADDRESS 7620 York Road, Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 2, 1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Charles Judge		25a. REC'D BY REGISTRAR Charles Judge	
25b. ADDRESS 4611 Park Heights Ave.		25c. DATE MAR 2 1967	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18, above, Pages 1, 2, and 3 of this funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b Hours ??	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Plant Dispensary, Beth Steel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emory		4. DATE OF DEATH Month 2 Day 7 Year 1967	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-6-07	
9. AGE (in years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 2 Days 7	
11. IF UNDER 24 HRS. Hours 19 Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Emory Wolfe		14. MOTHER'S MAIDEN NAME Anna Carter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 178-07-3185	
17. INFORMANT (Wife) Virginia Wolfe, 37 Stabilizer Dr. Middle River		Address Md. 21220	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary-Arterio-scleriotic cardio vascular disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stat (c) Stat PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. N		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) O	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) None	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		22. DATE SIGNED 2-7-67	
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		6800 Morningside Rd., Dundalk, Md. 21222	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/67	
23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR FEB 9 1967	
25b. REGISTRAR'S SIGNATURE John J. Duda			



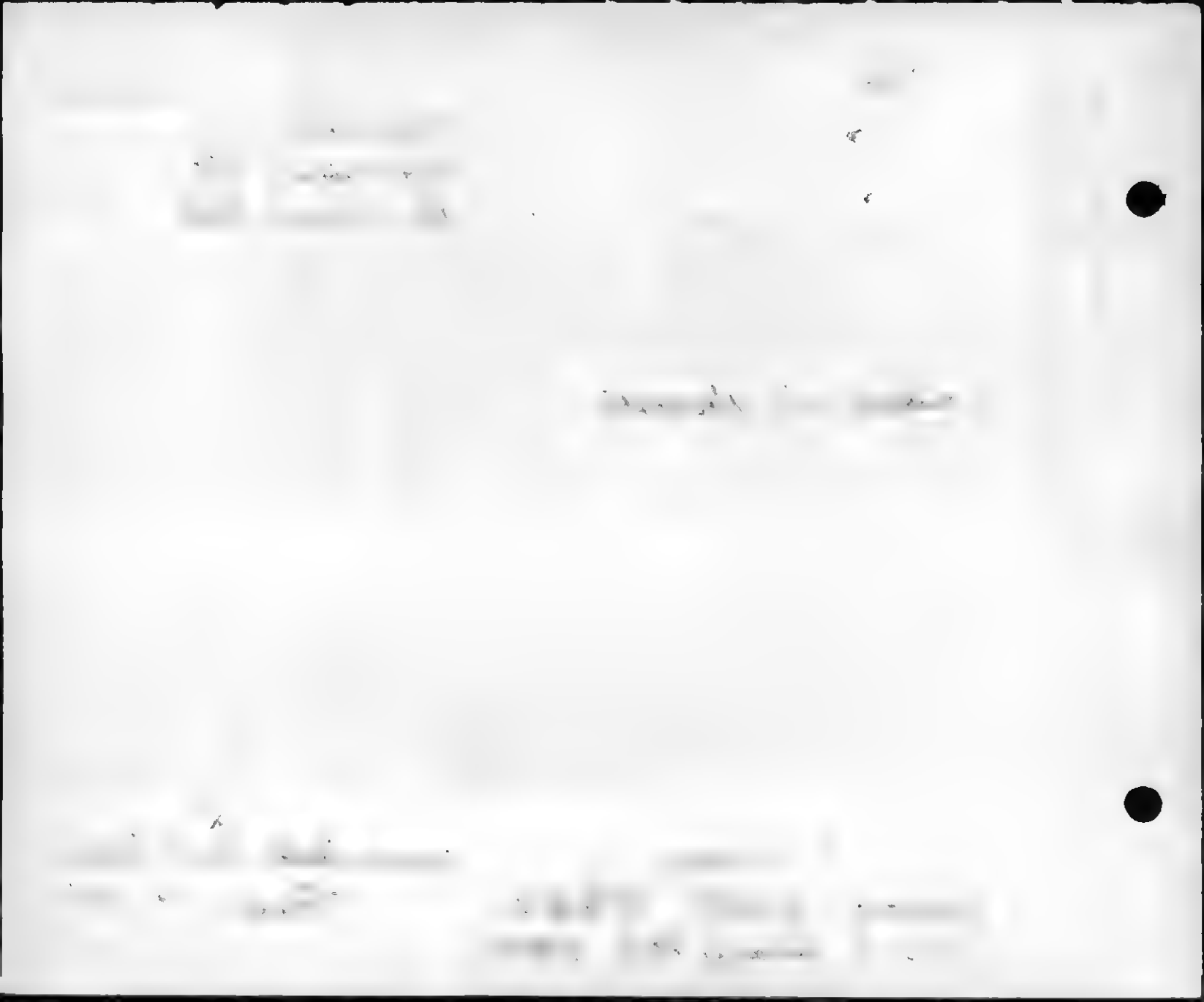
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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01993
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY GREATER Balt. Medical Center BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEHALL, MD.	
c. LENGTH OF STAY IN 1b 2 HRS.		d. STREET ADDRESS Mc COMAS ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE Medical Center			
3. NAME OF DECEASED (Type or print) First Middle Last Baby WOODWARD		4. DATE OF DEATH Month Day Year 12 17 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-67
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months Days Hours Min. 2 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Towson, Balto. Co.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOSEPH J. WOODWARD		14. MOTHER'S MAIDEN NAME Barbara GELSTON	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-17, 1967, to 2-17, 1967, that (I) (we) last saw the deceased alive on 2-17, 1967, and that death occurred at 4:20 PM, from the causes and on the date stated above.			
22a. SIGNATURE C. Simmons		22b. DATE SIGNED 2-17-67	
22c. PHYSICIAN'S NAME (Type) C. Simmons		22d. ADDRESS Greater Balt. Med. Center	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 2/20/67	
23c. NAME OF CEMETERY OR CREMATORY G.B.M.C.		23d. LOCATION (City, town or county) (State) Towson, Md.	
25a. REC'D BY REGISTRAR DATE MAY 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01994

CERTIFICATE OF DEATH

01989

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CATON RIDGE NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>4376 PARKTON ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROBERTA ZIEGLER</u> First Middle Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/18/1890</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>76</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				4. DATE OF DEATH Month <u>2</u> - Day <u>12</u> - Year <u>1967</u> 13. FATHER'S NAME <u>ROBERT PORTER</u> 14. MOTHER'S MAIDEN NAME <u>ANNA DANIELS</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>CLIFTON E. ZIEGLER</u> Address <u>416 STRATFORD RD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>① Bronchopneumonia</u> DUE TO (b) <u>② Probably Aspiration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>③ Arteriosclerotic Dementia (C.B.S.)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - Hiatus Hernia - Old Fr. Rt Femoral Neck</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>5-3-</u> , 19 <u>63</u> , to <u>2-12-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-12-1967</u> , and that death occurred at <u>12 AM</u> , from causes and on the date stated above. 22a. SIGNATURE <u>Cesar Valle Caverio</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2-12-67</u> 22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u> 22d. ADDRESS <u>8629 LIBERTY RD</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 24. FUNERAL DIRECTOR <u>WEBER FUNERAL HOME</u>		23b. DATE THEREOF <u>2/15/1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u> 23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MARYLAND</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>FEB 14 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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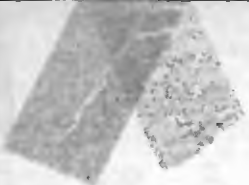
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01995

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01990

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Highlands				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Highlands			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2813 Oak Grove Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ZOUCK Last ZOUCK				4. DATE OF DEATH Month February Day 8 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-31-1907	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 59 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franklin H. Zouck				14. MOTHER'S MAIDEN NAME Elizabeth Gardner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 139-03-2080		17. INFORMANT 6230 Division Road Mr. Howard L. Houck, Huntington, West Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebellar Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breiteneker, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2/9/67	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-11-1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue				ADDRESS 21229		25a. REC'D BY REGISTRAR FEB 14 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



12310

STATE

